



1. FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 2 7 6 4 3

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MARY MIDDLE FRANCES LAST ALT			2a. DATE OF DEATH MONTH NOVEMBER DAY 1, YEAR 1982		2b. HOUR 06:35 AM		
3 SEX Female		4 RACE White		5. DATE OF BIRTH MONTH April DAY 9, YEAR 1939		6. AGE (IN YEARS LAST BIRTHDAY) 43 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) W.Va.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH ALLEGANY COUNTY, MD	
10. CITY OR TOWN OF DEATH Cumberland		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SACRED HEART HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housekeeping		12b. KIND OF BUSINESS OR INDUSTRY Nursing Home	
13a. STATE W.Va.		13b. COUNTY Mineral		13c. CITY OR TOWN New Creek		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST Virgil MIDDLE HOOPER LAST Hoover		15. MOTHER'S MAIDEN NAME FIRST CELIA MIDDLE ARONHALT LAST Aronhalt					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) None		17. INFORMANT ADDRESS Miss Karen Alt, Box 122, New Creek, W.Va.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: 1749 IMMEDIATE CAUSE (a) Superior vena cava obstruction DUE TO, OR AS A CONSEQUENCE OF (b) Ca of breast with metastasis DUE TO, OR AS A CONSEQUENCE OF (c) to lung - brain - bone - APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 9-3-82, to 11-1-82, that (I) (we) lost saw the deceased alive on 11-1-82, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE John Mehanne MD		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 11-1-82			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) JOHN MEHANNE, M.D.		22e. ADDRESS 909-B SETON DRIVE CUMBERLAND, MD 21502					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Nov. 4, 1982		23c. NAME OF CEMETERY OR CREMATORY Evans Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Maysville Grant W.Va.	
24. FUNERAL DIRECTOR Markwood Funeral Home		11. MINERAL STREET KEYSER, WV 26726		25a. DATE REC'D. BY REGISTRAR NOV 8 1982		25b. REGISTRAR'S SIGNATURE John J. Smith	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death and retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed in the office of the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				8 2 2 7 6 4 4 REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) <b>LESSA MABEL BAGEANT</b>				2a. DATE OF DEATH MONTH DAY YEAR <b>November 29, 1982</b>			
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>Jan. 17, 1895</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>87</b> YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>West Virginia</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Allegany</b> MD.	
10. CITY OR TOWN OF DEATH <b>CUMBERLAND</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>MEMORIAL HOSPITAL</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Retired</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Hospital</b>	
13a. STATE <b>Maryland</b>				13b. COUNTY <b>Allegany</b>		13c. CITY OR TOWN <b>Cumberland</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Emory Holliday</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Grace Hovermale</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>no</b>		16b. SOCIAL SECURITY NO. <b>218-30-0422</b>		17. INFORMANT ADDRESS <b>Mrs. Anna L. Reed, Cumberland, Md. Daughter</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <b>4100</b> IMMEDIATE CAUSE (a) <b>acute myocardial infarction</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>ASCVD</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>no</b>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>11/29</b> , 19 <b>82</b> , to <b>11/29</b> , 19 <b>82</b> , that (I) (we) last saw the deceased alive on <b>11/29</b> , 19 <b>82</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>THADDEUS ELDER</b>				DEGREE <b>MD</b> ATTENDING <input checked="" type="checkbox"/> MEDICAL <input type="checkbox"/> STAFF <input type="checkbox"/> PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>11/29/82</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>DR. THADDEUS ELDER</b>				22e. ADDRESS <b>CUMBERLAND, MARYLAND 21502</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>Dec. 2, 1982</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Hillcrest Burial Park</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Cumberland, Allegany, Md.</b>	
24. FUNERAL DIRECTOR NAME <b>James F. Scarpelli, Cumberland, Md.</b>				25a. DATE REC'D. BY REGISTRAR <b>DEC 7 1982</b>			





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DHMH - 16 50M 4/82  
(VRA 15, 4)

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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 2 7 6 4 5

REG. NO.

1. FOR STATE REGISTRAR		2a. DATE OF DEATH		MONTH	DAY	YEAR	2b. HOUR
1. DECEASED NAME (TYPE OR PRINT)		THOMAS FRANCIS BAKER		NOVEMBER 23, 1982			M
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR	
MALE	WHITE	APRIL 4 DAY 1908		74		MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH			
MARYLAND	U.S.A.			ALLEGANY COUNTY, MD.			
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY		
CUMBERLAND	SACRED HEART HOSPITAL		LABORER		BREWERY		
13a. STATE		13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS	
MARYLAND		ALLEGANY	MIDLAND	YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		BOX 55	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		ADDRESS			
THOMAS F. BAKER SR.		MARY C. BRODERICK		MIDLAND, MD.			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (IF YES, GIVE WAR OR DATES)		16b. SOCIAL SECURITY NO.		17. INFORMANT			
NO		214-05-5625		CATHERINE BRODERICK			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>4029 Congestive Heart Failure</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Hypertensive and atherosclerotic heart Disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u></u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>2 years</u> <u>years.</u>					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>Chronic renal failure; adenocarcinoma of the colon; Chronic obstructive Lung disease.</u>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
				YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>Sept</u> 19 <u>81</u> , to <u>Nov 23</u> 19 <u>82</u> , tho (I) (we) lost saw the deceased alive on <u>Nov 22</u> 19 <u>82</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <u>Th. Devlin M.D.</u>		DEGREE MD		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 11-23-82	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) THOMAS DEVLIN, M.D.		22e. ADDRESS 55 JACKSON ST., LONACONING, MD 21539					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 11/26/82		23c. NAME OF CEMETERY OR CREMATORY ST. MICHAELS		23d. LOCATION CITY OR TOWN COUNTY STATE MIDLAND ALLEGANY MD.	
24. FUNERAL DIRECTOR NAME <u>Wayne Bowh.</u> ADDRESS <u>21562</u>		25a. DATE REC'D. BY REGISTRAR NOV 29 1982		25b. REGISTRAR'S SIGNATURE <u>Joan J. Canish</u>			
BOAL FUNERAL HOME		111 CHURCH ST., WESTERNPORT					



DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 2 7 6 4 6

REG. NO.

1- FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>EVELYN NMN BARKDOLL</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>11 25 1982</b>		2b. HOUR <b>0057HRS</b>	
3. SEX <b>FEMALE</b>		4. RACE <b>WHITE</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>FEB 26 1903</b>		
6. AGE (IN YEARS LAST BIRTHDAY) <b>79</b> YRS.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>ALLEGANY COUNTY</b> MD.		
7b. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7c. CITIZEN OF WHAT COUNTRY? <b>U S A</b>		10. CITY OR TOWN OF DEATH <b>CUMBERLAND</b>		
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>MEMORIAL HOSPITAL</b>			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Housewife,</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>	
13a. STATE <b>MARYLAND</b>		13b. COUNTY <b>ALLEGANY</b>		13c. CITY OR TOWN <b>CUMBERLAND</b>		
14. FATHER'S NAME FIRST MIDDLE LAST <b>Frank C. Myers</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Annie -- Griffith</b>		16. STREET ADDRESS <b>213 WASHINGTON STREET Apt. # 1</b>		
17a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR (UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>No.</b>		17b. SOCIAL SECURITY NO. <b>21-05-5105</b>		17c. INFORMANT ADDRESS <b>Mr. Thomas M. Berry, 10 Greene St. Cumb. Md.</b>		
18. CAUSE OF DEATH (Enter only one cause per line for PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiovascular Arrest</b> <b>4149</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <b>Myocardial CHD + CAD</b> (c) <b>ASCVD c CVD + ONI</b> PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>11:24 PM 11/25/82</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) <b>82 Nov 25 82</b>		
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) <b>82</b>		21f. LOCATION CITY OR TOWN COUNTY STATE <b>Nov 25 82</b>		
22a. I certify that (1) (this hospital) (entered the deceased from) <b>Nov 24 82</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If the local doctor did not view the body after death.)						
22b. SIGNATURE <b>William S. M.D.</b>		DEGREE <b>M.D.</b>		22c. DATE SIGNED <b>11-25-82</b>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>TEWILLIAM S. M.D.</b>		22e. ADDRESS <b>MEMORIAL MED. CTR. CUMBERLAND, MD.</b>				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>11/28/82</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Hillcrest Burial Park,</b>		
24. FUNERAL DIRECTOR NAME ADDRESS <b>H. Wayne George 202 Greene St. Cumberland, Md.</b>		25a. DATE REC'D. BY REGISTRAR <b>DEC 1 1982</b>		25b. REGISTRAR'S SIGNATURE <b>John J. Connel</b>		

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be returned by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use in the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8 2 2 7 6 4 7		
1. FOR STATE REGISTRAR			REG. NO.									
1 DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE OF DEATH MONTH DAY YEAR			2b. HOUR			
EDGAR H. BENDER						11 1 82			12:35 PM			
3. SEX			4 RACE			5 DATE OF BIRTH MONTH DAY YEAR			6 AGE (IN YEARS LAST BIRTHDAY)			
Male			Caucasian			8 29 86			96 YRS.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9 BALTIMORE CITY OR COUNTY OF DEATH			
West Virginia			USA						Allegany County MD.			
10 CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)									
Frostburg			Frostburg Village Nursing Home									
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY									
Plant Supervisor			Telephone Co									
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)												
13a. STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS?			
MD			Allegany			Cumberland			YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
14 FATHER'S NAME FIRST MIDDLE LAST						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST						
Frank Bender						C. Elizabeth Smith						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)						16b. SOCIAL SECURITY NO.			17 INFORMANT ADDRESS			
Unknown						212-10-0558A			Dorothy Oster, Cumberland, MD 21502			
11 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiovascular arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>CVD, TIA, Semility</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>ASLVD</u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)												
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED						20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
									YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (I) (this hospital) attended the deceased from <u>Nov 1 1982</u> to <u>Oct 31 1982</u> , that (I) (we) lost <u>Nov 1 1982</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												
22b. SIGNATURE						DEGREE			22c. DATE SIGNED			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)						22e. ADDRESS						
Dr. Shin Eung Kim						Main Street, Westernport, MD						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION CITY OR TOWN COUNTY STATE			
Burial			Nov 4, 1982			Rose Hill Mausoleum			Cumberland Allegany Maryland			
24 FUNERAL DIRECTOR NAME			ADDRESS			25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE			
Silcox-Merritt Funeral Service.			Cumberland, Md			NOV 3 1982			John J. Carver			

ASAP  
C/O. TIA, Seattle  
C/O. TIA, Seattle

Nov 1 82  
[Signature]

Nov 1 82

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be retained by the funeral director within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				8 2 2 7 6 4 8			
1. FOR STATE REGISTRAR				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Louisa Lottie Bestwick				2a. DATE OF DEATH MONTH DAY YEAR 11 26 82		2b. HOUR 6:55 AM	
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Dec. 16, 1897		6. AGE (IN YEARS LAST BIRTHDAY) 84	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) England		7b. CITIZEN OF WHAT COUNTRY? U. S. A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Allegany MD.	
10. CITY OR TOWN OF DEATH Cumberland,		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Cumberland Nursing Center		12a. USUAL OCCUPATION (TYPE OF WORK OR MOST OF WORKING LIFE) Housewife,		12b. KIND OF BUSINESS OR INDUSTRY Own Home	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland 13b. COUNTY Allegany 13c. CITY OR TOWN Cumberland,				13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
14. FATHER'S NAME FIRST MIDDLE LAST James Henry Boots				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Caroline -- Hone			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No,		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS Mrs. Joyce B. Macey, Rt. # 1 Box 42-A Lavale, Md. 21502			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: 4280 IMMEDIATE CAUSE (a) CHF. DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } DUE TO, OR AS A CONSEQUENCE OF (c) _____ PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) _____ General debility.							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 11/23/82, 1982, to 11/26/82, 1982, that (I) (we) last saw the deceased alive on 11/25/82, 1982, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE J. H. HARMON				DEGREE MD ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 11/28/82	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) J. H. HARMON				22e. ADDRESS 302 Schley St. Cumberland			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 11/29/82		23c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery, 21502		23d. LOCATION CITY OR TOWN COUNTY STATE Cumberland, Allegany Maryland	
24. FUNERAL DIRECTOR H. Wayne George 202 Greene St. Cumberland, Md.				25a. DATE REC'D. BY REGISTRAR DEC 1 1982		25b. REGISTRAR'S SIGNATURE John J. Conner	

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STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				8 2 2 7 6 4 9			
FOR 1 - STATE REGISTRAR				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) <b>MAUDE MAY BLAND</b>				2a. DATE OF DEATH MONTH DAY YEAR <b>NOVEMBER 4, 1982</b>		2b. HOUR <b>8:40 A.M.</b>	
3. SEX <b>FEMALE</b>		4. RACE <b>WHITE</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>8 - 14 - 1897</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>85</b> YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN) <b>MARYLAND</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>ALLEGANY COUNTY</b> MD.	
10. CITY OR TOWN OF DEATH <b>CUMBERLAND</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>SACKED HEART HOSPITAL</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
13. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>MD</b> 13b. COUNTY <b>ALLEGANY</b> 13c. CITY OR TOWN <b>FROSTBURG</b> 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> 13e. STREET ADDRESS <b>FROSTBURG, MD</b>							
14. FATHER'S NAME (FIRST, MIDDLE, LAST) <b>JOSEPH TRANUM</b>				15. MOTHER'S MAIDEN NAME (FIRST, MIDDLE, LAST) <b>EILEEN WILSON</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>NO</b>		16b. SOCIAL SECURITY NO. <b>216-76-6386</b>		17. INFORMANT ADDRESS <b>MRS. LILLIAN HAGGARD FROSTBURG, MD</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>myocardial infarction</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>arteriosclerotic cardiovascular disease</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>diabetic neuropathy</b> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>4100</b> <b>2 days</b> <b>20 yrs</b>							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOT BY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>11 2</b> , 19 <b>82</b> , to <b>11 3</b> , 19 <b>82</b> , that (I) (we) lost saw the deceased alive on <b>11 3</b> , 19 <b>82</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>Donald Manger</b>		DEGREE <b>M.D.</b>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>11 4 82</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>DONALD MANGER, M.D.</b>		22e. ADDRESS <b>55 JACKSON ST., LONA CONING, MD. 21539</b>					
23a. BURIAL, CREMATION, REMOVAL (TYPE) <b>BURIAL</b>		23b. DATE <b>11 - 8 - 82</b>		23c. NAME OF CEMETERY OR CREMATORY <b>SOUTH LAWN MEM. CEM.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>COLONIAL HEIGHTS CHESTERFIELD VA.</b>	
24. FUNERAL DIRECTOR'S NAME <b>BOAL'S FUNERAL HOME</b>				24b. ADDRESS <b>WESTERNPORT, MD.</b>		25. DATE REC'D. BY POSTAL REGISTRAR <b>NOV 8 1982</b>	

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DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 2 7 6 5 0

1- FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>ESTELLA IRENE BOWMAN</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>October 25, 1982</b>		2b. HOUR M				
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>8 18 04</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>78</b> YRS. MONTHS DAYS HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>W. Va.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Allegany</b> MD.			
10. CITY OR TOWN OF DEATH <b>Cumberland</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Memorial Hospital</b>			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Homemaker</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>		
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Allegany</b>		13c. CITY OR TOWN <b>Little Orleans</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <b>General delivery</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>John Beatty</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Rebecca Shingleton</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>Unknown</b>		16b. SOCIAL SECURITY NO. <b>217-28-2400</b>		17. INFORMANT ADDRESS <b>Paul Bowman Little Orleans, Md.</b>					
18. CAUSE OF DEATH (Enter only one cause per line. Do not include conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART 1. DEATH WAS CAUSED BY: <b>4149 Cardiac Arrest</b> <b>Admitted severe CAD</b> <b>Myocardial CHF</b> DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>Aspirin</b>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE <b>Oct 22 82 Oct 13 82</b>					
22a. I certify that (1) (this hospital) received the deceased from <b>Oct 13 82</b> to <b>Oct 13 82</b> , that (1) (we) last saw the deceased alive on <b>Oct 13 82</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>Dr. T. Williams</b>				DEGREE <b>MD</b>		22c. DATE SIGNED <b>10-28-82</b>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Dr. T. Williams</b>				22e. ADDRESS <b>Memorial Medical Building Cumberland, Md. 21502</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>10-27-1982</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Buck Valley Christian Warfordsburg</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Fulton Penna.</b>			
24. FUNERAL DIRECTOR NAME <b>Richard J. Howe</b>				ADDRESS <b>Hancock Md.</b>		25a. DATE REC'D. BY REGISTRAR <b>NOV 3 1982</b>			
				25b. REGISTRAR'S SIGNATURE <b>John J. Connel</b>					

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## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				8 2 2 7 6 5 1 REG. NO.					
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST JANET HAYES BRENNEMAN				2a. DATE OF DEATH MONTH DAY YEAR NOVEMBER 4, 1982				2b. HOUR 2:45 PM	
3. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR APRIL 7, 1900		6. AGE (IN YEARS LAST BIRTHDAY) 82 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH ALLEGANY COUNTY MD.			
10. CITY OR TOWN OF DEATH CUMBERLAND		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SACRED HEART HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOUSEWIFE		12b. KIND OF BUSINESS OR INDUSTRY OWN HOME	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MARYLAND				13b. COUNTY ALLEGANY		13c. CITY OR TOWN FROSTBURG		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST SALEM HAYES				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ANNIE HOPKINS					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) NO				16b. SOCIAL SECURITY NO. 236-14-7650		17. INFORMANT ADDRESS MRS. GENEVIEVE KEMP, FROSTBURG MD.			
18. CAUSE OF DEATH (Enter only one cause per line form (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4360 Cerebrovascular Accident DUE TO, OR AS A CONSEQUENCE OF (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO, OR AS A CONSEQUENCE OF (c)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3dgs	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a									
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
22a. I certify that (I) (this' hospital) attended the deceased from 10-31, 1982, to 11-11, 1982, that (I) (we) last saw the deceased alive on 11-11, 1982, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE WAYNE SPIGGLE, M.D.				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS 912 SETON DRIVE CUMBERLAND, MD					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL				23b. DATE NOV. 6, 1982		23c. NAME OF CEMETERY OR CREMATORY FROSTBURG MEMORIAL PARK FROSTBURG, ALLEGANY, MD.		23d. LOCATION CITY OR TOWN COUNTY STATE	
24. FUNERAL DIRECTOR NAME DURST FUNERAL HOME				ADDRESS 57 FROST AVE. FROSTBURG, MD.		25a. DATE PREP'D BY REGISTRAR NOV 12 1982		25b. REGISTRAR'S SIGNATURE	



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STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				8 2 2 7 6 5 2			
1. FOR STATE REGISTRAR				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) THOMAS STANDISH BRODE				2a. DATE OF DEATH MONTH DAY YEAR NOVEMBER 18, 1982		2b. HOUR 04:45 AM	
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR 5/10/05		6. AGE (IN YEARS LAST BIRTHDAY) 77 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH ALLEGANY COUNTY, MD.	
10. CITY OR TOWN OF DEATH CUMBERLAND		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SACRED HEART HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) LABORER		12b. KIND OF BUSINESS OR INDUSTRY ABL	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE) 13a. STATE MARYLAND 13b. COUNTY ALLEGANY 13c. CITY OR TOWN LAVALE				13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 68 NATIONAL HIGHWAY	
14. FATHER'S NAME FIRST MIDDLE LAST SOLOMON BRODE				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST KATE S. MERRILL			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) N.A. 213-09-7328		17. INFORMANT ADDRESS MRS. THOMAS S. BRODE, 68 NATIONAL HWY., LAVALE, MD. 21502			
18. CAUSE OF DEATH: Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Terminal Carcinoma of Esophagus</i> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ 1509							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) <i>Rectal Carcinoma</i>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <i>Gary Wagoner M.D.</i>				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 11-18-82	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) GARY WAGONER, M.D.				22e. ADDRESS 925 BISHOP WALSH RD., CUMBERLAND, MD 21502			
23a. BURIAL, CREMATION, REMOVAL BURIAL		23b. DATE 11/20/82		23c. NAME OF CEMETERY OR CREMATORY BRODE CEMETERY		23d. LOCATION CITY OR TOWN COUNTY STATE FROSTBURG ALLEGANY MD.	
24a. NAME OF FUNERAL HOME <i>Walter M. Sowers</i>		ADDRESS 60 W. MAIN STREET FROSTBURG, MD 21532		25a. DATE REC'D. BY REGISTRAR NOV 23 1982		25b. REGISTRAR'S SIGNATURE <i>John J. Connel</i>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO. 8 2 2 7 6 5 3			
1. FOR STATE REGISTRAR				2a. DATE OF DEATH MONTH DAY YEAR			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST CHARLES EDWARD BURCAW				November 18, 1982			
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Oct. 14, 1903		6. AGE (IN YEARS LAST BIRTHDAY) 79 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Ohio		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Allegany MD.	
10. CITY OR TOWN OF DEATH CUMBERLAND		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) MEMORIAL HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired		12b. KIND OF BUSINESS OR INDUSTRY Steel Co.	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)				13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
13a. STATE Md.		13b. COUNTY Allegany		13c. CITY OR TOWN Cumberland		13e. STREET ADDRESS 108 Wempe Drive	
14. FATHER'S NAME FIRST MIDDLE LAST George Burcaw				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Deibel			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 214-05-6826		17. INFORMANT ADDRESS Mrs. Alleene Burcaw, Cumberland, Md. Wife			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Vasculitis to cardiac arteries</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Unknown</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>4476</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: <u>none</u>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		19c. AUTOPTSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN PART I OR PART 2) <u>NOT AVAILABLE</u>			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE <u>108 Wempe Drive</u> <u>Cumberland</u> <u>Allegany</u> <u>Md.</u>			
22a. I certify that (this hospital) attended the deceased from <u>11/18/82</u> to <u>11/18/82</u> (I) (we) last saw (he) (she) (it) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <u>W. F. Scarpelli</u>				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <u>11/18/82</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) DR. GUY FISCUS				22e. ADDRESS MEMORIAL HOSPITAL MEDICAL BUILDING CUMBERLAND, MARYLAND 21502			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 11-21-1982		23c. NAME OF CEMETERY OR CREMATORY Hillcrest Burial Park		23d. LOCATION CITY OR TOWN COUNTY STATE Cumberland, Allegany, Md.	
24. FUNERAL DIRECTOR NAME James F. Scarpelli, Cumberland, Md.				25a. DATE REC'D. BY REGISTRAR NOV 24 1982		25b. REGISTRAR'S SIGNATURE <u>John J. Conner</u>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filled within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. FOR STATE REGISTRAR				STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO. 8 2 2 7 6 5 4			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST BERNICE NMI BURNS				2a. DATE OF DEATH MONTH DAY YEAR NOVEMBER 7, 1982				2b. HOUR 10:25A			
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Sept. 12, 1910		6. AGE (IN YEARS LAST BIRTHDAY) 72 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) W. Va.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH ALLEGANY COUNTY, MD					
10. CITY OR TOWN OF DEATH Cumberland		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION SACRED HEART HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Reg. Nurse		12b. KIND OF BUSINESS OR INDUSTRY Nursing			
13a. STATE W. Va.				13b. COUNTY Mineral		13c. CITY OR TOWN Keyser		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 87 First Street	
14. FATHER'S NAME FIRST MIDDLE LAST Noah Adam Burns				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Lillie Jane Wiles							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. None		17. INFORMANT ADDRESS Miss Ada Burns, 87 First Street, Keyser, W. Va.							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 1749 IMMEDIATE CAUSE (a) <u>Cerebral metastasis</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Ca of breast with metastasis.</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>11-7-82</u> to <u>11-7-82</u> , that (I) (we) lost the deceased alive on <u>11-7-82</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) not view the body after death.											
22b. SIGNATURE <u>Meahanna</u>				DEGREE M.D.				ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 11-8-82	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) MEHANNA, JOHN M.D.				22e. ADDRESS 909-B SETON DR., CUMBERLAND, MD. 21502							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Nov. 9, 1982		23c. NAME OF CEMETERY OR CREMATORY Queens Point Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Keyser Mineral W. V.					
24. FUNERAL DIRECTOR MARKWOOD F.H.; 11 MINERAL ST. KEYSER, WV. 26726				25a. DATE REC'D. BY REGISTRAR NOV 12 1982		25b. REGISTRAR'S SIGNATURE <u>John J. Cairns</u>					

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of once.

BP

DHMH - 16 50M 4/82  
(VRA 15, 4)

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 2 7 0 5 5

REG. NO.

1. FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST LILLIAN MAY CAIN			2a. DATE OF DEATH MONTH DAY YEAR NOVEMBER 10, 1982		2b. HOUR 6:10 P.M.
3. SEX Female	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR March 28, 1905	6. AGE (IN YEARS LAST BIRTHDAY) 77 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md.	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH ALLEGANY COUNTY MD.		
10. CITY OR TOWN OF DEATH CUMBERLAND	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SACRED HEART HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) homemaker	12b. KIND OF BUSINESS OR INDUSTRY Own home	

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)					
13a. STATE Md.	13b. COUNTY Allegany	13c. CITY OR TOWN Mc Coole	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS 160 Queen Street	
14. FATHER'S NAME FIRST MIDDLE LAST James M. Tharp			15. MOTHER'S MAIDEN NAME MIDDLE LAST Anna Parkes		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 219-46-0148		17. INFORMANT ADDRESS Mrs. Linda Heare, 34 Va. Street, Keyser, W. Va.	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4100 DUE TO, OR AS A CONSEQUENCE OF (b) Heart failure - Renal failure DUE TO, OR AS A CONSEQUENCE OF (c) Coronary Heart Disease DUE TO, OR AS A CONSEQUENCE OF (c) Acute Myocardial Infarction - Previous anterior MI 1972		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 d. 710y.
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)		

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 11/5, 1982, to 11/10, 1982, that (I) (we) lost saw the deceased alive on 11/10, 1982, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE V. Rual Felipa		DEGREE MD		22c. DATE SIGNED 11/11/82	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) V. RUAL FELIPA, M.D.		22e. ADDRESS 925 BISHOP WALSH DRIVE, CUMBERLAND, MD 21502			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE Nov. 13, 1982	23c. NAME OF CEMETERY OR CREMATORY Potomac Memorial Gardens, Keyser	23d. LOCATION CITY OR TOWN COUNTY STATE Mineral W. Va.
23e. FUNERAL HOME MARKWOOD FUNERAL HOME		23f. ADDRESS KEYSER, WVA 26726	23g. DATE REC'D. BY REGISTRAR NOV 16 1982
23h. REGISTRAR'S SIGNATURE John J. Conner		23i. REGISTRAR'S SIGNATURE	

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PW 3. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, BALTIMORE, MARYLAND; 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH-17  
(VR A15 ME (5))  
15M 2/80

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1. FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <b>GEORGE ROSAIRE CHAPUT</b>			2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> ESTIMATED <input type="checkbox"/> <b>11/27/1982</b>			2b. HOUR <b>1345</b>		
3. SEX <b>M</b>	4. RACE <b>Cau</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>10/16/15</b>	6. AGE (IN YEARS) LAST BIRTHDAY YRS. <b>67</b>	IF UNDER 1 YR. MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	7c. DATE PRONOUNCED DEAD <b>11/27/82</b>	2d. HOUR <b>1500</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>New Hamp. USA</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Allegany</b> MD.		
10. CITY OR TOWN OF DEATH <b>Nr. Oldtown,</b>		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Greenridge Forest</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Retired</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Truck Driver</b>
13a. STATE <b>New Hm.</b>			13b. CITY OR TOWN <b>Hillboro,</b>	13c. CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13d. STREET ADDRESS <b>121 Liberty Hill Road</b>			
14. FATHER'S NAME FIRST MIDDLE LAST <b>Narcisse Chaput</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Florence Demers</b>			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>No</b>		
16b. SOCIAL SECURITY NO. <b>002-07-2424</b>			17. INFORMANT <b>Dr. Raymond Chaput(son)</b>			ADDRESS <b>Whenton Md. 12407 Flack</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: <b>4100 IMMEDIATE CAUSE (a) Acute Myocardial Infarction</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost: (b) <b>Coronary Artery Heart disease</b> DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>Sudden</b> <b>7 years</b>								
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). <b>Hypertension</b>								
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .								
ACTUAL SIGNATURE <b>Paul Snow</b>			TITLE (SPECIFY) <b>Asst. Dpty</b>			DATE SIGNED <b>11/27/82</b>		
EXAMINER'S NAME (TYPE OR PRINT) <b>Paul Snow, M.D.</b>			ADDRESS <b>Memorial H0spital</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			23b. DATE <b>12/1/82</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Mount Calvary Cemetery,</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Manchester, Hillboro, N. H.</b>	
24. FUNERAL DIRECTOR <b>H. Wayne George</b>			ADDRESS <b>202 Greene St. Cumberland, Md.</b>		25a. DATE REC'D. BY REGISTRAR <b>DEC 1 1982</b>		25b. REGISTRAR'S SIGNATURE <b>John J. Lohr</b>	

STANDARD FORM NO. 64  
MAY 1962 EDITION  
GSA FPMR (41 CFR) 101-11.6

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101-11.6



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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 2 7 6 5 7

1- FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST MARGARET <del>XX E. COFFEY</del> COFFEY			2a. DATE OF DEATH MONTH DAY YEAR NOVEMBER 12, 1982		2b. HOUR 10:00A <sub>M</sub>
3. SEX Female	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR July 6, 1903		6. AGE (IN YEARS LAST BIRTHDAY) 79 YRS.	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH ALLEGANY COUNTY, MD.	
10. CITY OR TOWN OF DEATH Cumberland	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SACRED HEART HOSPITAL			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Owner/Operator	
13a. STATE Md.			13b. COUNTY Allegany	13c. CITY OR TOWN Cumberland	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST Stephen Augustus Nally			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Delia Cecelia Reynolds		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 217-14-4338		17. INFORMANT ADDRESS Mr. James B. Coffey, Sr., Cumberland, Md.	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Endstage Carcinoma of Mammary Gland</u> 1701 DUE TO, OR AS A CONSEQUENCE OF (b) <u>metastases</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Months
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: a		

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (the hospital) attended the deceased from <u>11/12/82</u> to <u>11/12/82</u> , that (I) (we) last saw the deceased alive on <u>11/12/82</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. <u>XX</u>			
22b. SIGNATURE <u>Bradley A. Stewart</u>	DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	22c. DATE SIGNED <u>11-14-82</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) WAGONER, GARY M.D.	22e. ADDRESS 925 BISHOP WALSH RD. CUMBERLAND, MD. 21502		

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) burial	23b. DATE 11/15/82	23c. NAME OF CEMETERY OR CREMATORY Oakland Cemetery	23d. LOCATION CITY OR TOWN COUNTY STATE Oakland, Garrett, Maryland
24. FUNERAL DIRECTOR NAME Bradley A. Stewart STEWART F.H.; OAKLAND, MD. 21500		25. DATE REC'D. BY REGISTRAR NOV 23 1982	
		26. REGISTRAR'S SIGNATURE <u>John J. Connelley</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MONTH 12 1982

RECEIVED 241 0000 1982

ALABAMA COUNTY

SARASOTA BEACH HOSPITAL

*Multiple Lesions / Metastatic*

*Metastatic*

2002 18TH AVE SW, CANTON, MS 39002

WAGNER, GARY W.

STEWART F.H. O'NEILL, JR. 31582

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				8 2 2 7 6 5 8			
1. FOR STATE REGISTRAR				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST ETHEL MARGARET COLLINS				2a. DATE OF DEATH MONTH DAY YEAR NOVEMBER 3, 1982		2b. HOUR 5:25 A M	
3. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR SEPT 12 1909		6. AGE (IN YEARS LAST BIRTHDAY) 73 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH ALLEGANY MD	
10. CITY OR TOWN OF DEATH CUMBERLAND		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) MEMORIAL HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOUSEWIFE		12b. KIND OF BUSINESS OR INDUSTRY	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)				13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
13a. STATE MARYLAND		13b. COUNTY ALLEGANY		13c. CITY OR TOWN CUMBERLAND		13e. STREET ADDRESS 240 COLUMBIA STREET	
14. FATHER'S NAME FIRST MIDDLE LAST CHARLES WILLIAM EHRBAR				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MARGARET KNO CHE			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 213-24-6600		17. INFORMANT ADDRESS NORMAN COLLINS 240 COLUMBIA ST CUMBERLAND MD			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardio respiratory arrest</u> 4360 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cerebrovascular accident</u> DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 21502							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (b) <u>Coronary artery disease Dehydration</u>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that <u>Dr</u> (this hospital) attended the deceased from <u>11/2/82</u> to <u>11/3/82</u> , that <u>we</u> lost <u>saw</u> the deceased alive on <u>11/3/82</u> , and that <u>in (my) (our)</u> opinion death occurred on the date and hour and from the causes stated above, <u>(I) (we) (did)</u> (did not) view the body after death.							
22b. SIGNATURE <u>Shan Nathan</u>				DEGREE ATTENDING MEDICAL STAFF PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED NOV 3, 1982	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) DR. SHAN NATHAN				22e. ADDRESS MEMORIAL HOSPITAL MEDICAL BUILDING CUMBERLAND, MARYLAND 21502			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE NOV 6 1982		23c. NAME OF CEMETERY OR CREMATORY SUNSET MEMORIAL PARK		23d. LOCATION CITY OR TOWN COUNTY STATE CUMBERLAND ALLEGANY MARYLAND	
24. FUNERAL DIRECTOR NAME ADDRESS SILCOX-MERRITT FUNERAL SERVICE CUMBERLAND MD.				25a. DATE REC'D. BY REGISTRAR NOV 5 1982		25b. REGISTRAR'S SIGNATURE <u>John J. Conner</u>	

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2) - 2-25

BUHTAL



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the Medical Examiner must be notified at once.

BP

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 2 7 6 5 9

REG. NO.

1. FOR STATE REGISTRAR			2a. DATE OF DEATH			MONTH DAY YEAR			2b. HOUR		
1. DECEASED NAME (TYPE OR PRINT)			THOMAS FLOYD COOK			NOVEMBER 23, 1982			12:50A <sub>M</sub>		
3. SEX			4. RACE			5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)		
Male			Cau			11 MONTH 03 YEAR 1916			66 YRS.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH		
Pa.			USA						ALLEGANY COUNTY, MD.		
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY		
Cumberland			SACRED HEART HOSPITAL			Textile worker			Textile		
13a. STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS?		
Pa.			Bedford			Hyndman			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.		
J. HOWARD COOK			ANNEBELLE RIZER			no			214 07 6308		
17. INFORMANT			ADDRESS			17a. DATE OF OPERATION			17b. CONDITION FOR WHICH OPERATION WAS PERFORMED		
Mae F. Cook, R D 1, Box 408, Hyndman, Pa.											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)			19. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?		
PART I. DEATH WAS CAUSED BY:						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			YES <input type="checkbox"/> NO <input type="checkbox"/>		
1850 IMMEDIATE CAUSE (a) Respiratory failure											
DUE TO, OR AS A CONSEQUENCE OF											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.											
(b) Ca of prostate = pulm. metastasis											
DUE TO, OR AS A CONSEQUENCE OF											
(c)											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)											
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			21d. INJURY OCCURRED		
			P.M. 19						21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK									21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from 11-17, 1982, to 11-23, 1982, that (I) (we) last saw the deceased alive on 11-23-1982, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.			22b. SIGNATURE			DEGREE			22c. DATE SIGNED		
			John Mehanna M.D.			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			11-24-82		
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			22e. ADDRESS			23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE		
JOHN MEHANNA, M.D.			909-B SETON DR., CUMBERLAND, MD 21502			Burial			11/26/82		
23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION CITY OR TOWN COUNTY STATE			24. FUNERAL DIRECTOR NAME			25a. DATE REC'D. BY REGISTRAR		
Palo Alto Cemetery			Londonderry Twp, Bedford, Pa.			ZIEGLER FUNERAL HOME			NOV 30 1982		
						HYNDMAN, PA15545			John J. Conner		

MEDICAL CERTIFICATION





TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. GIVE PAGE 4 TO THE CHIEF MEDICAL EXAMINER. ALONG WITH FORM PM 3, RETAIN PAGE 5 FOR THE FUNERAL DIRECTOR. PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH-17  
(VRA 15 ME (5))  
15M 2/80

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

FOR  
1- STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)			2a. DATE KNOWN OF DEATH			2b. DATE OF DEATH			2c. DATE PRONOUNCED DEAD			2d. DATE OF DEATH		
Leona V. Davidson			11 15 1982			11 15 1982			11 16 1982			10:00 PM		
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS)	7. IF UNDER 1 YR.	8. IF UNDER 24 HRS.	9. BALTIMORE CITY OR COUNTY OF DEATH			10. BALTIMORE CITY OR COUNTY OF DEATH			11. BALTIMORE CITY OR COUNTY OF DEATH		
Female	White	June 23, 1904	78 YRS.			Allegany			Allegany			Allegany		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED			9. BALTIMORE CITY OR COUNTY OF DEATH			10. BALTIMORE CITY OR COUNTY OF DEATH		
Maryland			USA			WIDOWED			Allegany			Allegany		
12. CITY OR TOWN OF DEATH			13. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION			14. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			15. KIND OF BUSINESS OR INDUSTRY			16. KIND OF BUSINESS OR INDUSTRY		
Cumberland			43 New Hampshire Ave.			Housewife			In Own Home			In Own Home		
17. USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)			18. COUNTY			19. CITY OR TOWN			20. INSIDE CITY LIMITS?			21. STREET ADDRESS		
Maryland			Allegany			Cumberland			YES			43 New Hampshire Ave.		
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME			16. SOCIAL SECURITY NO.			17. INFORMANT			18. ADDRESS		
William Karnes			Nancy Martin			214-05-6155			Mrs. Charlotte Deatelhauser, Daughter			Mrs. Charlotte Deatelhauser, Daughter		
19a. WAS DECEASED EVER IN U.S. ARMED FORCES?			19b. SOCIAL SECURITY NO.			19c. INFORMANT			19d. ADDRESS			19e. ADDRESS		
no			214-05-6155			Mrs. Charlotte Deatelhauser, Daughter			Mrs. Charlotte Deatelhauser, Daughter			Mrs. Charlotte Deatelhauser, Daughter		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 1 DEATH WAS CAUSED BY:														
IMMEDIATE CAUSE (a) <u>Heart Failure</u>														
DUE TO, OR AS A CONSEQUENCE OF														
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.														
(b) <u>Arterio sclerotic heart disease.</u>														
DUE TO, OR AS A CONSEQUENCE OF														
(c)														
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).														
<u>Adenocarcinoma of Uterus.</u>														
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY?			21. AUTOPSY?			22. AUTOPSY?		
						YES			NO			NO		
21a. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH			21b. TIME OF INJURY			21c. HOW INJURY OCCURRED			21d. INJURY OCCURRED			21e. PLACE OF INJURY		
			HOUR A.M. MONTH DAY YEAR			ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2			CITY OR TOWN			COUNTY		
			P.M. 19						STREET			STATE		
21d. INJURY OCCURRED WHILE AT WORK			21e. PLACE OF INJURY			21f. LOCATION			21g. LOCATION			21h. LOCATION		
NOT WHILE AT WORK			(AT HOME, STREET, FACTORY, FARM, ETC.)			STREET			CITY OR TOWN			COUNTY		
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .														
ACTUAL SIGNATURE			TITLE (SPECIFY)			DATE SIGNED			DATE SIGNED			DATE SIGNED		
Nicholas Giarritta			Deputy			11-16-1982			11-16-1982			11-16-1982		
EXAMINER'S NAME			ADDRESS			ADDRESS			ADDRESS			ADDRESS		
NICHOLAS GIARRITTA			800 SETON DRIVE			800 SETON DRIVE			800 SETON DRIVE			800 SETON DRIVE		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORY			23d. CITY OR TOWN			23e. COUNTY		
Burial			11-19-82			Davis Memorial Cemetery			Cumberland			Allegany, Md.		
24. FUNERAL DIRECTOR			25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE			25c. REGISTRAR'S SIGNATURE			25d. REGISTRAR'S SIGNATURE		
James F. Scarpelli			NOV 22 1982			John J. Givier			John J. Givier			John J. Givier		

George V. Davidson

June 12, 1904

Thomas White

Albany

Ida

Maryland

Albany

65 1st Avenue

Christiana

Albany

William Brown

210-07-1100

11-11-1905

Albany

11-11-1905

Albany

Albany Memorial Society

James T. Davidson

Albany

Albany Memorial Society

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO. 8 2 2 7 6 6 1			
1. FOR STATE REGISTRAR							
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>RAY LESTER DAVIS</b>				2a. DATE OF DEATH MONTH DAY YEAR <b>NOVEMBER 17, 1982</b>			
3. SEX <b>Male</b>				2b. HOUR <b>1:35 A.M.</b>			
4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>Oct. 6, 1907</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>75</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>West Virginia</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			
10. CITY OR TOWN OF DEATH <b>Cumberland</b>				9. BALTIMORE CITY OR COUNTY OF DEATH <b>ALLEGANY COUNTY, MD.</b>			
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>SACRED HEART HOSPITAL</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Retired</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Textile</b>	
13a. STATE <b>Maryland</b>				13b. COUNTY <b>Allegany</b>		13c. CITY OR TOWN <b>Cumberland</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Charles B. Davis</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Martha E. Hinkle</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>				16b. SOCIAL SECURITY NO. <b>214-07-3554</b>		17. INFORMANT ADDRESS <b>Mrs. Louise C. Miller, Daughter</b>	
18. CAUSE OF DEATH (Enter only one cause per line; (a), (b), and (c) are for PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Endstage COPD</b> <b>4960</b> DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>CHF, Renal failure</b>							
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) find the body after death.							
22b. SIGNATURE <i>[Signature]</i>				DEGREE <b>MD</b>		22c. DATE SIGNED <b>11-17-82</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>GARY WAGONER, M.D.</b>				22e. ADDRESS <b>925 BISHOP WALSH RD., CUMBERLAND, MD 21502</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>11-20-1982</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Zion Memorial Park</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Cumberland, Allegany Md.</b>	
24. FUNERAL DIRECTOR NAME <b>SCARPELLI FUNERAL HOME</b>				25a. DATE REC'D. BY REGISTRAR <b>NOV 22 1982</b>			
ADDRESS <b>108 VIRGINIA AVE., CUMBERLAND, MD</b>				REGISTRAR'S SIGNATURE <i>[Signature]</i>			



DAY	WESTER	DAVIS	WESTER 12 1902
Male	White	Col. B. 1902	75
Year of birth	1902	X	ALLIANCE COUNTY
Occupation	SACRED HEART HOSPITAL	Religious	Textile
Married	Alfred	Occupation	Thomas Addition
Divorced B. Davis	Textile		
1910-1914	Mr. Louisa C. Miller, daughter		

21-07-1914

CHP 1914

1914

1914

SCOTT'S BAPTIST CHURCH 102 VIRGINIA AVE. COLUMBIANA, MISSISSIPPI  
 11-20-1962 - Honorary work - Studyings - 11-20-1962  
 222 RIDGE WALKER RD., COLUMBIANA, MS 39021

BP

DHMH-17  
(VR A15 ME (5))  
15M 2/80

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. GIVE PAGE 4 TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR RECORDS. GIVE PAGES 6, 7, 8, AND 9 TO THE FUNERAL DIRECTOR. PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 24 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 2 2 7 6 6 2	
1. DECEASED NAME (TYPE OR PRINT) <b>CHRISTINA MARIE DELAWDER</b>							2b. DATE KNOWN OF DEATH MONTH DAY YEAR <b>11/9/82</b>		2c. HOUR a <b>6:00</b> m		
3. SEX <b>FEMALE</b>		4. RACE <b>WHITE</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>DEC 11 1981</b>		6. AGE (IN YEARS) LAST BIRTHDAY MONTHS DAYS HOURS MIN. <b>11</b>		7c. DATE PRONOUNCED DEAD MONTH DAY YEAR <b>11/9/82</b>		2d. HOUR a <b>6:40</b> m	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>CUMBERLAND, MD</b>				7b. CITIZEN OF WHAT COUNTRY? <b>U S A</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>ALLEGANY</b> MD.			
10. CITY OR TOWN OF DEATH <b>CUMBERLAND</b>				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>DOA MEMORIAL HOSPITAL</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE <b>MARYLAND</b>				13b. COUNTY <b>ALLEGANY</b>		13c. CITY OR TOWN <b>CUMBERLAND</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>447 GOETHE STREET</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>UNKNOWN</b>						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>NAOMI RUTH DELAWDER</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)				16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS <b>WILMA DAYHOFF 12 1/2 BLACKSTON AVE. CUMB, MD</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: <b>7670 IMMEDIATE CAUSE (a) Respiratory Arrest</b> Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last: <b>Brain Damage</b> (b) <b>Brain Damage</b> DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE <i>Giovanni Mastrangelo</i>				TITLE (SPECIFY) <b>Deputy</b>				DATE SIGNED <b>11/9/82</b>			
EXAMINER'S NAME (TYPE OR PRINT) <b>Giovanni Mastrangelo, M.D.</b>				ADDRESS <b>900 Seton Drive Cumberland</b>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>				23b. DATE <b>11-11-1982</b>		23c. NAME OF CEMETERY OR CREMATORY <b>RESTLAWN CEMETERY</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>LAVALE ALLEGANY MARYLAND</b>			
24. FUNERAL DIRECTOR NAME ADDRESS <b>LEASURE-STEIN FUNERAL HOME, INC. CUMBERLAND, MD</b>				25a. DATE REC'D. BY REGISTRAR <b>NOV 12 1982</b>				25b. REGISTRAR'S SIGNATURE <i>John J. Connel</i>			



11

1561

11-11-11



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 2 7 6 6 3

1- FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST SARAH REBECCA DEVORE			2a. DATE OF DEATH MONTH DAY YEAR November 18, 1982		2b. HOUR 11:25 A M						
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR March 27, 1989		6. AGE (IN YEARS LAST BIRTHDAY) 93 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) West Virginia		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Allegany MD.					
10. CITY OR TOWN OF DEATH CUMBERLAND		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) MEMORIAL HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY Own Home			
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)											
13a. STATE Maryland		13b. COUNTY Allegany		13c. CITY OR TOWN Cumberland		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 456 Williams Street 21502			
14. FATHER'S NAME FIRST MIDDLE LAST Joseph Barnhart				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Martha True							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No				16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 213-48-8028		17. INFORMANT ADDRESS J. Harold DeVore, Cumberland, Maryland					

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

4140

DUE TO, OR AS A CONSEQUENCE OF

(b) Arteriosclerotic Heart Disease with

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.

DUE TO, OR AS A CONSEQUENCE OF Congestive Heart Failure

(c)

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)

Urinary Tract Infection; Sexuality

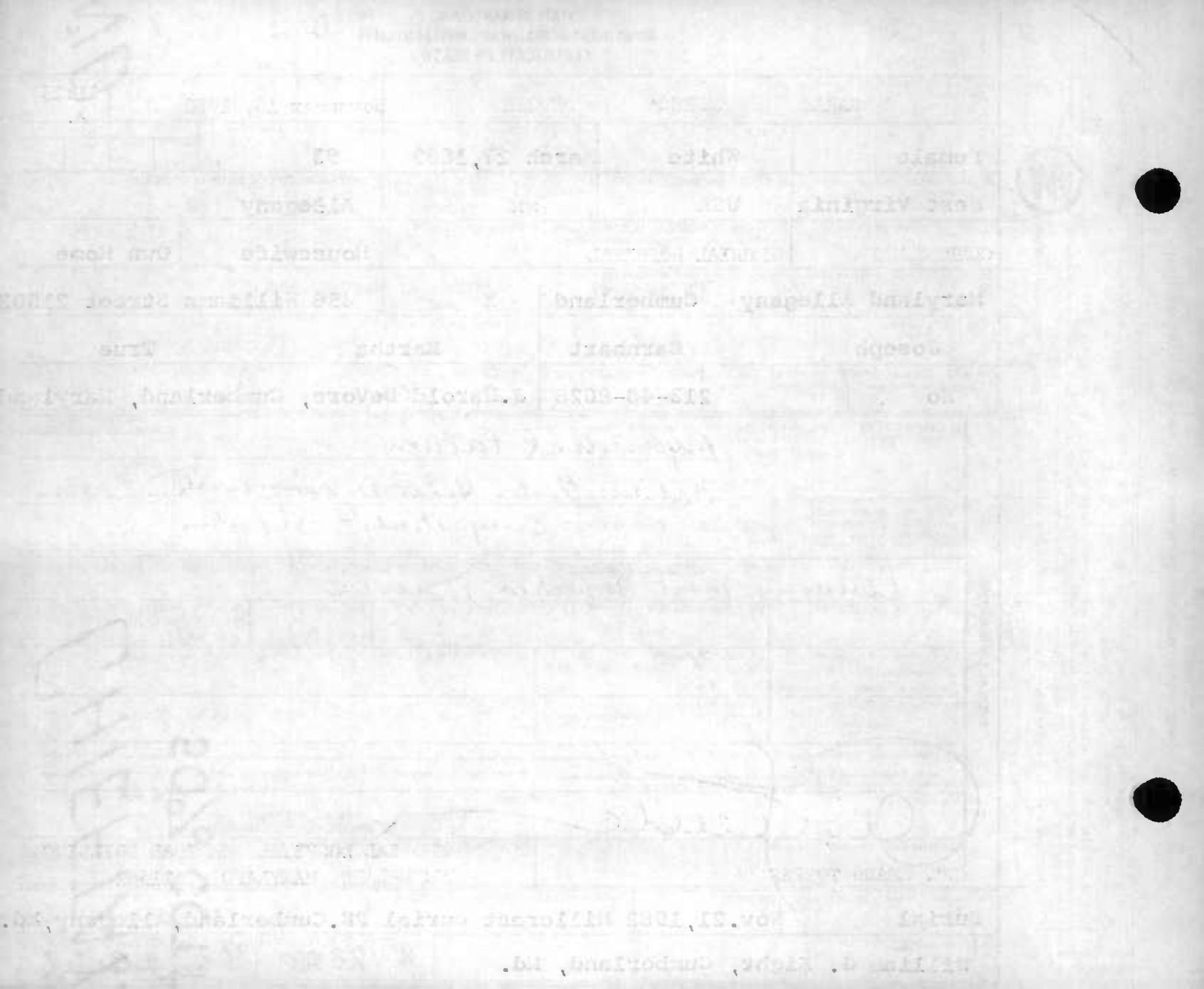
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) _____ the body after death.							
22b. SIGNATURE DR. AMADO TORRES				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED	
22e. PHYSICIAN'S NAME (TYPE OR PRINT) DR. AMADO TORRES				22d. ADDRESS MEMORIAL HOSPITAL MEDICAL BUILDING CUMBERLAND, MARYLAND 21502			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Nov. 21, 1982		23c. NAME OF CEMETERY OR CREMATORY Hillcrest Burial PK. Cumberland, Allegany, Md.		23d. LOCATION CITY OR TOWN COUNTY STATE	
24. FUNERAL DIRECTOR NAME ADDRESS William G. Kight, Cumberland, Md.				25a. DATE REC'D. BY REGISTRAR NOV 26 1982		25b. REGISTRAR'S SIGNATURE John J. Conner	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the body after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner (must be notified as required by law).



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with a 22-30-01 after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO. 8 2 2 7 6 6 4			
1. FOR STATE REGISTRAR				1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST			
PAUL WILLIAM DIXON				2a. DATE OF DEATH MONTH DAY YEAR 2b. HOUR			
NOVEMBER 15, 1982 12:10 AM							
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY) IF UNDER 1 YEAR IF UNDER 24 HRS	
Male		White		6 21 1939		43 YRS. MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH	
W. Va.		USA				ALLEGANY COUNTY, MD.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
Cumberland		SACRED HEART HOSPITAL		Truck Driver		Trucking	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b. STATE 13c. CITY OR TOWN				13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> 13e. STREET ADDRESS			
W. Va. Mineral Keyser				Rt #1			
14. FATHER'S NAME FIRST MIDDLE LAST				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST			
James Dixon				Edna R. Kitzmiller			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)				16b. SOCIAL SECURITY NO. 17. INFORMANT ADDRESS			
No				UNK David A. Burdock Kitzmiller, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1. DEATH WAS CAUSED BY: 5728 IMMEDIATE CAUSE (a) Liver failure							3 days
DUE TO, OR AS A CONSEQUENCE OF (b) ASHD, arteriosclerosis							31 years
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) Alcoholism							15 years
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE				DEGREE		22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		11-16-82	
George Byrd MD				BMG-912 SETON DRIVE CUMBERLAND, MD 21502			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE	
Burial		11-17-82		Kalbaugh Cemetery		Elk Garden Mineral W. Va	
24. FUNERAL DIRECTOR NAME		P.O. BOX 523 ADDRESS		25. DATE REC'D BY REGISTRAR		26. REGISTRAR'S SIGNATURE	
BURDOCK FUNERAL HOME		KITZMILLER, MD 21538		NOV 24 1982		John J. Gaudin	

BP



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17  
(VR A15 ME (5))  
15M 2/80

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1. FOR STATE REGISTRAR		2. 2 2 7 6 6 5	
1. DECEASED NAME (TYPE OR PRINT) <b>Lawrence Edward Ellsworth</b>			
3. SEX <b>Male</b>	4. RACE <b>White</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>March 22 1910 72</b>	6. AGE (IN YEARS) (LAST BIRTHDAY) YRS. <b>72</b>
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U S A</b>	
8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Allegany</b>	
10. CITY OR TOWN OF DEATH <b>LaVale</b>		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>D O A Sacred Heart Hospital</b>	
12a. USUAL OCCUPATION (TYPE OF WORK, FOR MOST OF WORKING LIFE) <b>Maintenance</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Railroad</b>	
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Allegany</b>	13c. CITY OR TOWN <b>LaVale</b>
14. FATHER'S NAME FIRST MIDDLE LAST <b>Benjamin <del>XXXXXX</del> Neal Ellsworth</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Florence Meders</b>	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>705-10-6103</b>	
17. INFORMANT <b>Mary A. Ellsworth</b>		ADDRESS <b>same as above</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial Infarction</b> 4100 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) <b>Arteriosclerotic Heart Disease</b> (c) _____ DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) _____			
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)	
21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .			
ACTUAL SIGNATURE <i>Giovanni Mastrangelo</i>		TITLE (SPECIFY) <b>Deputy</b> MEDICAL EXAMINER	
EXAMINER'S NAME (TYPE OR PRINT) <b>Giovanni Mastrangelo</b>		DATE SIGNED <b>11/14/82</b>	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>11/17/82</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Rest Lawn Memorial</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>LaVale Allegany Maryland</b>	
24. FUNERAL DIRECTOR NAME ADDRESS <b>John J. Hafer LaVale, Md. 21502</b>		25a. DATE REC'D. BY REGISTRAR <b>NOV 17 1982</b>	
		25b. REGISTRAR'S SIGNATURE <i>John J. Coniff</i>	

[illegible]

705-10-0103 - JURY A. [REDACTED] and as above

STOWELL, DON HENRY

90297071

1990

1752

original

6155

47055

ET-796

Et voilà

1995

2011-2012 • 555

58/2/00

Table 1

S312717

Page 12 of 13

578481

— 1999/2000



DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2

2 7 6 6 6

1. FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>Frances L. Eyler</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>11-8-82</b>			2b. HOUR <b>11:45am</b>			
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>Mar. 17, 1901</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>81</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. IF UNDER 24 HRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Penna.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Allegany</b> MD.			
10. CITY OR TOWN OF DEATH <b>Cumberland</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Cumberland Nursing Center</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Housewife</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Own home</b>	
13a. STATE <b>MD</b>		13b. COUNTY <b>Allegany</b>		13c. CITY OR TOWN <b>Cumberland</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>21502 608 Montgomery Ave.</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Jacob A. Thomas</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Rosella Shull</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>212-32-8363B</b>		17. INFORMANT <b>Edward E. Eyler, Sr. LaVale, MD</b>		ADDRESS <b>21502</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial infarction - probable</b> <b>4100</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) _____									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>2/5 1981</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) <b>11/8</b>				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE <b>302 Schley St. Cumberland</b>				
22a. I certify that (i) (this hospital) attended the deceased from <b>4/12</b> 19 <b>81</b> , to <b>11/8</b> 19 <b>82</b> , that (i) (we) last saw the deceased alive <b>4/12</b> 19 <b>81</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (i) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>William G. Kight</b>			DEGREE <b>MD</b>			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>11/8/82</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>W. HAZ MOJ</b>			22e. ADDRESS <b>302 Schley St. Cumberland</b>						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Cremation</b>			23b. DATE <b>Nov. 9, 1982</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Smithsburg Crematory Smithsburg Wash. MD</b>		23d. LOCATION CITY OR TOWN COUNTY STATE		
24. FUNERAL DIRECTOR NAME <b>William G. Kight</b>			ADDRESS <b>Cumberland, MD</b>		25a. DATE REC'D. BY REGISTRAR <b>NOV 12 1982</b>		25b. REGISTRAR'S SIGNATURE <b>John J. Carver</b>		

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MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1, 2, and 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

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FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) PAUL GLEN FARNER			2a. DATE OF DEATH MONTH DAY YEAR NOVEMBER 8, 1982		2b. HOUR 5:55 P.M.			
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR May 31 1927		6. AGE (IN YEARS LAST BIRTHDAY) MONTHS DAYS HOURS MIN. 55 YRS		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Salisbury, Pa.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH ALLEGANY COUNTY MD.		
10. CITY OR TOWN OF DEATH Cumberland		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SACRED HEART HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Cement Finisher Hgy. Const.		
13a. STATE Pa.		13b. COUNTY Somerset		13c. CITY OR TOWN Salisbury		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST Glen W Farner				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Lowry				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WW II		17. INFORMANT ADDRESS Pa. 15558				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 0543 IMMEDIATE CAUSE (a) Herpetic Encephalitis DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) systemic Herpes Zoster DUE TO, OR AS A CONSEQUENCE OF (c) Hodgkin's Disease		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH						
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from 10-21, 1982, to 11-8-1982, that (I) (we) lost saw the deceased alive on 11-8-1982, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE John Mehan				DEGREE M.D.		22c. DATE SIGNED 11-9-82		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) JOHN MEHANNA, M.D.				22e. ADDRESS 909-B SETON DRIVE, CUMBERLAND, MD 21502				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 11-11-82		23c. NAME OF CEMETERY OR CREMATORY SALISBURY CEMETERY		23d. LOCATION CITY OR TOWN COUNTY STATE SALISBURY - SOMERSET - PA		
24. FUNERAL DIRECTOR NAME ADDRESS THOMAS FUNERAL HOME: SALISBURY PA 101 GRANT ST				25a. DATE REC'D. BY REGISTRAR NOV 15 1982		25b. REGISTRAR'S SIGNATURE John J. Smith		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 2 7 6 6 8

1. FOR STATE REGISTRAR		REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) <b>Lee F. Fazenbaker</b>		2a. DATE OF DEATH MONTH <b>11</b> DAY <b>08</b> YEAR <b>82</b> 2b. HOUR <b>6:05 PM</b>	
3. SEX <b>Male</b>	4. RACE <b>White</b>	5. DATE OF BIRTH MONTH <b>03</b> DAY <b>09</b> YEAR <b>02</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MARYLAND</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
10. CITY OR TOWN OF DEATH <b>Frostburg</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Frostburg Community Hospital</b>	9. BALTIMORE CITY OR COUNTY OF DEATH <b>Allegany County</b> MD.	
12a. USUAL OCCUPATION (TYPE OF WORK OR MAIN WORKING LIFE) <b>RET. MINER</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>COAL</b>	
13a. STATE <b>Maryland</b>	13b. COUNTY <b>Allegany</b>	13c. CITY OR TOWN <b>Barton</b>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
13e. STREET ADDRESS <b>Star Route</b>		13f. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST <b>MARK</b> MIDDLE <b>FAZENBAKER</b> LAST <b>FAZENBAKER</b>		15. MOTHER'S MAIDEN NAME FIRST <b>MARY</b> MIDDLE <b>FAZENBAKER</b> LAST <b>FAZENBAKER</b>	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>Unknown</b>		16b. SOCIAL SECURITY NO. <b>217-03-5885</b>	
17. INFORMANT <b>K. Carter</b>		ADDRESS <b>48 Tarn Terrace, Frostburg, MD</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>PNEUMONIA RIGHT LUNG</b> <b>4860</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>INFILTRATING ADENOCARCINOMA OF RECTOSIGMOID WITH LIVER METASTASIS</b>			
19a. DATE OF OPERATION <b>NONE</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)		21d. LOCATION STREET CITY OR TOWN COUNTY STATE	
21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <b>4/5</b> , 19 <b>82</b> , to <b>11/8</b> , 19 <b>82</b> , that (I) (we) lost the deceased alive on <b>5:10 PM</b> , 19 <b>82</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.			
22b. SIGNATURE <b>S. Chang M.D.</b>		22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>S. Chang, M.D.</b>		22e. ADDRESS <b>48 Tarn Terrace, Frostburg, MD 21532</b>	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>		23b. DATE <b>11/11/82</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>MT VIEW CEMETERY</b>		23d. LOCATION CITY OR TOWN <b>MOSCOW MILLS ALLEGANY</b> COUNTY <b>MD.</b> STATE	
24. FUNERAL DIRECTOR NAME <b>Boals</b> ADDRESS <b>WESTERNPORT, MD.</b>		25a. DATE REC'D. BY REGISTRAR <b>NOV 16 1982</b>	
25b. REGISTRAR'S SIGNATURE <b>Boals</b>		25c. REGISTRAR'S SIGNATURE <b>Boals</b>	

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2. Check the following:

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Albany County

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 2 7 6 6 9

REG. NO.

1. FOR STATE REGISTRAR		2a. DATE OF DEATH MONTH DAY YEAR		2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT)		FIRST MIDDLE LAST		2b. HOUR	
CHARLES EDWIN FLAHERTY		NOVEMBER 12, 1982		2:15A M	
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR MONTHS DAYS	
Male	White	May 11, 1904	78 YRS.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH		
W. Va.	U. S. A.		ALLEGANY COUNTY, MD.		
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY
Cumberland,	SACRED HEART HOSPITAL		Office Mgr.		W. Va. Dent. Employee & Security
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13b. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13c. STREET ADDRESS		
13a. STATE W. Va.		13b. COUNTY Wood Co.	13c. CITY OR TOWN Vienna, 1721 Forrest Hill Drive,		
14. FATHER'S NAME FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST			
Frank X. Flaherty		Bertha V. Brysinger			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS		
Yes, W. W. # 2		232-09-3078	Burdette Funeral Home, 1016 Market St. 26101		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 4100 IMMEDIATE CAUSE (a) Myocardial infarction DUE TO, OR AS A CONSEQUENCE OF (b) ASCVD Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Renal failure.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 days
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
		P.M. 19			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE		DEGREE		22c. DATE SIGNED	
George Brysinger MD		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		11-12-82	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS			
BREZA, GEORGE M.D.		912 SETON DR., CUMBERLAND, MD. 21502			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE	
Burial	11/17/82	Mount Carmel Cem.		Parkersburg, Wood Co. W. Va.	
24. FUNERAL DIRECTOR		25a. DATE RECEIVED BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
H. Wayne George Cumberland, Md. for: BURDETTS F.H.; 1016 MARKET ST. PARKERSBURG, WV		NOV 15 1982		[Signature]	

BP

NOVEMBER 12, 1952

CHARLES EMMETT FLAHERTY

11-11-52

MILWAUKEE COUNTY

SACRED HEART HOSPITAL

1127 Forrest Hill, Waukegan, Ill.

Waukegan, Ill.

Waukegan, Ill.

Waukegan, Ill.

11-11-52

*Waukegan, Ill.*

*Waukegan, Ill.*

11-11-52

612 SEVEN DE, CHICAGO, ILL. 60608

BRETT, GEORGE H.D.

*George Brett*

Waukegan, Ill.

Waukegan, Ill.

Waukegan, Ill.

DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1- STATE REGISTRAR		MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO.					
1. DECEASED NAME (TYPE OR PRINT)												2a. DATE KNOWN OF DEATH		2b. HOUR			
Johna L. Forman												11-17-82		1455			
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS)		IF UNDER 1 YR.		IF UNDER 24 HRS.		7c. DATE PRONOUNCED DEAD		7d. HOUR			
F		Cau		11-19-62		19 YRS.						11-17-82		1455			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)				7b. CITIZEN OF WHAT COUNTRY?				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH					
W. Va.				USA								Allegany MD					
10. CITY OR TOWN OF DEATH				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)				12b. KIND OF BUSINESS OR INDUSTRY					
Cumberland				Memorial Hospital				U.S. Army				U.S. Army					
13a. STATE				13c. CITY OR TOWN				13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS							
W. Va.				Philippi				YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		1# Birch Lane							
14. FATHER'S NAME				15. MOTHER'S MAIDEN NAME				ADDRESS									
David Duckworth				Wilma Mouser				1 Birch Lane									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)				16b. SOCIAL SECURITY NO.				17. INFORMANT									
Yes				235-92-9854				Wilma Duckworth, Philippi, W. Va.									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)														26416		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART I DEATH WAS CAUSED BY:																1 day	
8199 IMMEDIATE CAUSE (a) Brain Stem Contusion																	
DUE TO, OR AS A CONSEQUENCE OF																	
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.																1 day	
(b) Automobile accident																	
DUE TO, OR AS A CONSEQUENCE OF																	
(c)																	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).																	
Mulptle pelvic fractures																	
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?												20. AUTOPSY?	
																YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)									
				6:30 P.M. 11-16-82				Automobile accident									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION									
				Rt 28				Rt 28 Near Petersburg West Virginia									
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural cause <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .																	
ACTUAL SIGNATURE				TITLE (SPECIFY)												DATE SIGNED	
[Signature]				M.D. Asit. Dpty MEDICAL EXAMINER												11-17-82	
EXAMINER'S NAME (TYPE OR PRINT)				ADDRESS													
Paul Snow, M.D.				Memorial Hospital- Cumberland													
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)				23b. DATE		23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION							
Burial				11/19/82		Mt. Vernon Memorial				Philippi Barbour W. Va.							
24. FUNERAL DIRECTOR				25a. DATE REC'D. BY REGISTRAR				25b. REGISTRAR'S SIGNATURE									
NAME ADDRESS				NOV 30 1982				[Signature]									
Carl R. Wright Philippi, W. Va.																	



FOX COLLECTION LIBRARY  
15 JAN 1974

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				8 2 2 7 6 7 1			
1 - STATE REGISTRAR				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST HALENA WILLARD GRIMM				2a. DATE OF DEATH MONTH DAY YEAR November 25, 1982		2b. HOUR a 5:33 M	
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Dec. 17, 1901		6. AGE (IN YEARS LAST BIRTHDAY) 80 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Allegany MD.	
10. CITY OR TOWN OF DEATH Cumberland		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Memorial Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY Own Home	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MD 13b. COUNTY Allegany 13c. CITY OR TOWN Cumberland				13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		14. STREET ADDRESS Rt # 5, Box 361 21502	
14. FATHER'S NAME FIRST MIDDLE LAST John W. Long				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Clara Smith			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 205-16-1031		17. INFORMANT ADDRESS Mrs. Betty Bookheimer, Cumberland, MD 21502			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Renal Failure</u> <u>5860</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Suppurative ADH infection</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ DUE TO, OR AS A CONSEQUENCE OF							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>1 yr.</u> <u>1 month</u>
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a <u>CAD</u>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from _____, 19 <u>77</u> , to <u>11-25-82</u> , 19 _____, that (I) (we) last saw the deceased alive on <u>11-24-82</u> , 19 _____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <u>John T. Whitmore MD</u>				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <u>11-26-82</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. John T. Whitmore				22e. ADDRESS 1068 National Hwy., LaVale, Md. 21502			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Nov. 28, 1982		23c. NAME OF CEMETERY OR CREMATORY Davis Mem. Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Cumberland Allegany MD	
24. FUNERAL DIRECTOR NAME John J. Hafer LaVale, MD				25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE NOV 30 1982 <u>John J. Hafer</u>			

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### Notes

Mrs. Betty Bookbinder, Cumberland, MD 21502

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John J. Walter, Jr.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |   |  | REG. NO. 62 27672   |  |  |  |
|---|--|---|--|---|--|--|--|
| 1. FOR STATE REGISTRAR  |  |   |  |   |  |  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT) FIRST MIDDLE LAST<br>JAMES TEE HANDLAN  |  |   |  | 2a. DATE OF DEATH MONTH DAY YEAR<br>NOVEMBER 30, 1982   |  | 2b. HOUR<br>03:35 AM   |  |
| 3. SEX<br>Male  |  | 4. RACE<br>White  |  | 5. DATE OF BIRTH MONTH DAY YEAR<br>Dec. 11, 1911  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>70 YRS.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>W. Va.   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>ALLEGANY COUNTY, MD.   |  |
| 10. CITY OR TOWN OF DEATH<br>Cumberland   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN STATE HAVE STATE NO. 45)<br>SACRED HEART HOSPITAL |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Academic Dean   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>College   |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE W. Va. 13b. COUNTY Mineral 13c. CITY OR TOWN Keyser   |  |   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  | 13e. STREET ADDRESS<br>329 D Street  |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>James T. Handlan   |  |   |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>Mary Z. Welty   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>None   |  | 17. INFORMANT ADDRESS<br>Mrs. James T. Handlan 329 D. Street, Keyser W. Va.   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>4100 IMMEDIATE CAUSE (a) ACUTE MYOCARDIAL INFARCTION<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) CORONARY ARTERY DISEASE<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) |  |   |  |   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:<br>PNEUMONIA, CEREBROVASCULAR ACCIDENT   |  |   |  |   |  |  |  |
| 19a. DATE OF OPERATION<br>—   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br>—   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION CITY OR TOWN COUNTY STATE   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 10-26-1982, to 11-30-1982, that (I) (we) lost saw the deceased alive on 11-29-1982, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |   |  |   |  |  |  |
| 22b. SIGNATURE<br>Blanchard, M.D.   |  |   |  | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>        |  | 22c. DATE SIGNED   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>BALJEET MAHAL, M.D.  |  |   |  | 22e. ADDRESS<br>909-B SETON DR., CUMBERLAND, MD 21502   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial  |  | 23b. DATE<br>Dec. 2, 1982   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>St. Thomas Cemetery   |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br>Keyser Mineral W. Va.   |  |
| 24a. FUNERAL HOME<br>MARKWOOD FUNERAL HOME  |  | 24b. ADDRESS<br>11 MINERAL STREET<br>KEYSER, WV 26726   |  | 25a. DATE REC'D BY REGISTRAR<br>DEC 6 1982  |  | 25b. REGISTRAR'S SIGNATURE<br>John J. Smith  |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at 1-800-335-1101.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |  | 8 2 2 7 6 7 3   |  |  |  |
|---|--|--|--|---|--|--|--|
| 1. FOR STATE REGISTRAR  |  |  |  | REG. NO.  |  |  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT) FIRST MIDDLE LAST<br>FREDA MABEL HAWKINS  |  |  |  | 2a. DATE OF DEATH MONTH DAY YEAR<br>November 5, 1982  |  |  |  |
| 3. SEX<br>Female  |  |  |  | 2b. HOUR<br>6:15 A.M.   |  |  |  |
| 4. RACE<br>White  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>June 25 1912   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>70 YRS.  |  | 7. IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Md.  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U. S. A.   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Allegany MD.   |  |
| 10. CITY OR TOWN OF DEATH<br>CUMBERLAND   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>MEMORIAL HOSPITAL |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Domestic  |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |
| 13a. STATE<br>Md.   |  | 13b. COUNTY<br>Allegany  |  | 13c. CITY OR TOWN<br>Westernport  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                            |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Dennis  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Mary Grove  |  | 13e. STREET ADDRESS<br>Rt. 1 Westernport Md.  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>219-01-3795   |  | 17. INFORMANT ADDRESS<br>Ervin Grove Westernport Md.  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cerebral aneurysm</u><br>3481<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last |  |  |  |   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a  |  |  |  |   |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2)  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>11/3</u> 19 <u>82</u> to <u>11/5</u> 19 <u>82</u> , that (I) (we) last saw the deceased alive on <u>11/3</u> 19 <u>82</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.      |  |  |  |   |  |  |  |
| 22b. SIGNATURE OF PHYSICIAN<br>DR. AGUSTO FIGUEROA  |  |  |  | 22c. DATE SIGNED<br>11/9/82   |  | 22d. ADDRESS<br>MEMORIAL HOSPITAL MED. BLDG.<br>CUMBERLAND, MD 21502   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial   |  | 23b. DATE<br>11/7/82   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Bloomington Cemetery  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Bloomington Garrett Md.  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Boal Funeral Service P. A. Westernport Md.  |  |  |  | 25a. DATE REC'D. BY REGISTRAR<br>NOV 16 1982  |  | 25b. REGISTRAR'S SIGNATURE<br>J. C. Conish   |  |

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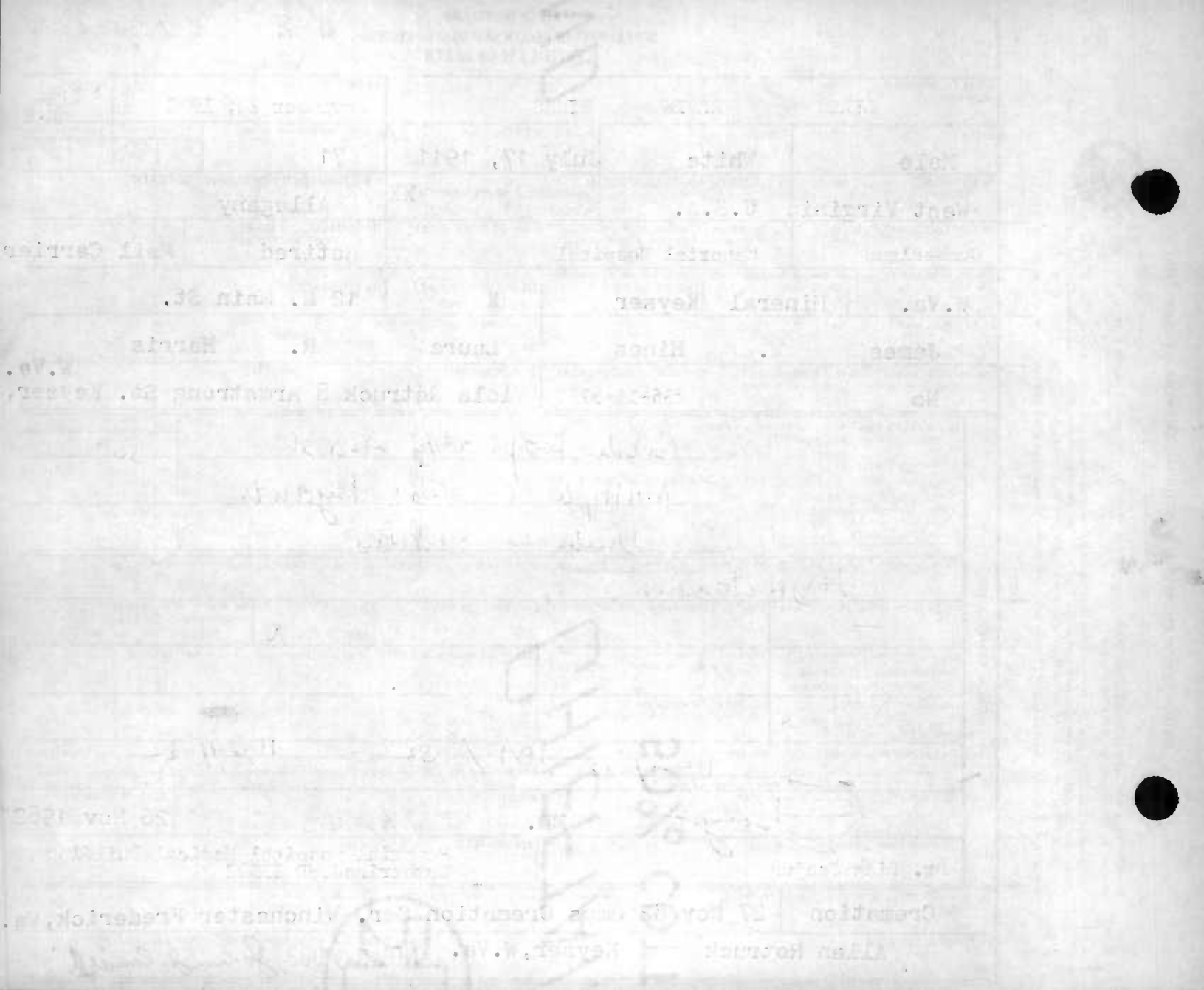
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |   |  | 8 2 2 7 6 7 4<br>REG. NO.   |  |  |  |  |  |
|--|--|---|--|---|--|--|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>LYLE ERVIN HINES</b>  |  |   |  | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>November 24, 1982</b>  |  |  |  | 2b. HOUR<br><b>8:46</b><br>P.M.  |  |
| 3. SEX<br><b>Male</b>  |  | 4. RACE<br><b>White</b>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>July 17, 1911</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>71</b> YRS.                                    |  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>West Virginia</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Allegany</b> MD.                          |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Cumberland</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Memorial Hospital</b> |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Retired</b>   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Mail Carrier</b>   |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><b>W.Va.</b>   |  |   |  | 13b. COUNTY<br><b>Mineral</b>   |  | 13c. CITY OR TOWN<br><b>Keyser</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                            |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>James W. Hines</b>  |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Laura R. Harris</b>   |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>  |  | 16b. SOCIAL SECURITY NO.<br><b>236-14-6758</b>  |  | 17. INFORMANT ADDRESS<br><b>W.Va. Viola Rotruck 8 Armstrong St. Keyser,</b>   |  |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br><b>2500 IMMEDIATE CAUSE (a) Cardio Respiratory Arrest</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Multiple Cerebral Injuries</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>Diabetes Mellitus</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. |  |   |  |   |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>30</b>  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>Hypertension</b>   |  |   |  |   |  |  |  |  |  |
| 19a. DATE OF OPERATION<br><b>—</b>   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)   |  |  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>10/12/1982</b> to <b>11/24/1982</b> , that (I) (we) lost saw the deceased alive on <b>11/24/1982</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (we) (did not) view the body after death.   |  |   |  |   |  |  |  |  |  |
| 22b. SIGNATURE<br><b>[Signature]</b><br>MD.  |  |   |  | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>        |  |  |  | 22c. DATE SIGNED<br><b>26 Nov 1982</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Dr. Riaz Janjua</b>  |  |   |  | 22e. ADDRESS<br><b>Memorial Hospital Medical Building Cumberland, MD 21502</b>  |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Cremation</b>   |  | 23b. DATE<br><b>27 Nov 82</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Omps Cremation Ser.</b>  |  | 23d. LOCATION<br>(CITY OR TOWN) COUNTY STATE<br><b>Winchester Frederick, Va.</b>     |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Allen Rotruck</b>   |  |   |  | ADDRESS<br><b>Keyser, W.Va.</b>   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>NOV 30 1982</b>                                  |  | REGISTRAR'S SIGNATURE<br><b>[Signature]</b>  |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 7 days with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of it.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |   |  | REG. NO.  |  |  |  |
|---|--|---|--|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>SUSAN BEALL HITCHINS</b>   |  |   |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>NOVEMBER 1, 1982</b>  |  | 2b. HOUR<br><b>3:25 P.M.</b>   |  |
| 3. SEX<br><b>Female</b>   |  | 4. RACE<br><b>White</b>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>August 29, 1895</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>87</b> YRS.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>ALLEGANY COUNTY</b> MD.   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Cumberland</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>SACRED HEART HOSPITAL</b> |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Homemaker</b>  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Own Home</b>   |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |  |   |  | 13a. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  | 13b. STREET ADDRESS<br><b>825 Buckingham Rd.</b>   |  |
| 13a. STATE<br><b>Maryland</b>   |  | 13b. COUNTY<br><b>Allegany</b>  |  | 13c. CITY OR TOWN<br><b>Cumberland</b>  |  |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Olen Beall</b>   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Florence Glenn</b>  |  | 16. ADDRESS<br><b>J. Glenn Beall Jr., Frostburg, Md.</b>  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>   |  | 16b. SOCIAL SECURITY NO.<br><b>218-50-2420</b>  |  | 17. INFORMANT<br><b>J. Glenn Beall Jr., Frostburg, Md.</b>  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Massive Myocardial infarction</b><br>4100<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last:<br>(b) <b>Atherosclerotic Heart Disease</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>Periphrical Vascular Disease, Severe.</b> |  |   |  |   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)  |  |   |  |   |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost<br>saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above. (I) (we) (did) (did not) view the body after death.   |  |   |  |   |  |  |  |
| 22b. SIGNATURE<br><i>Kenneth M. D.</i>  |  |   |  | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>        |  | 22c. DATE SIGNED   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>ZIENKIEWICZ, KENNETH, M.D.</b>  |  |   |  | 22e. ADDRESS<br><b>925 BISHOP WALSH RD., CUMBERLAND, MD. 21502</b>  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>   |  | 23b. DATE<br><b>Nov. 4, 1982</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Frostburg Mem. Park Frostburg, Md.</b>   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>DURST FUNERAL HOME</b>   |  | ADDRESS<br><b>57 FROST AVENUE<br/>FROSTBURG, MD. 21532</b>  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>NOV 12 1982</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><i>R. A. Carver</i>  |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |   |  | REG. NO. 8 2 2 7 6 7 6  |  |   |  |
|--|--|---|--|---|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) MAY BLANCHE HORN   |  |   |  | 2a. DATE OF DEATH MONTH DAY YEAR NOVEMBER 5, 1982   |  |   |  |
| 3. SEX Female  |  |   |  | 2b. HOUR 9:55 PM  |  |   |  |
| 4. RACE White  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR Sept. 25, 1902   |  | 6. AGE (IN YEARS LAST BIRTHDAY) 80 YRS.   |  | IF UNDER 1 YEAR<br>MONTHS DAYS  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) W. Va.   |  | 7b. CITIZEN OF WHAT COUNTRY? U. S. A.   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH ALLEGANY COUNTY MD.  |  |
| 10. CITY OR TOWN OF DEATH Cumberland,  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SACRED HEART HOSPITAL |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife,  |  | 12b. KIND OF BUSINESS OR INDUSTRY Own Home  |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE Maryland 13b. COUNTY Allegany 13c. CITY OR TOWN Cumberland,   |  |   |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  |   |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST Isaac R. M. Iser   |  |   |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Hattie C. Harris   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO,  |  | 16b. SOCIAL SECURITY NO. 217-10-67870   |  | 17. INFORMANT ADDRESS 26755 Mr. James E. Horn, Rt. # 2, Ridgeley, W. Va.  |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Congestive Heart Failure<br>4292 DUE TO, OR AS A CONSEQUENCE OF AS CD<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO, OR AS A CONSEQUENCE OF (c) |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: CO PD & Cor pulmonary   |  |   |  |   |  |   |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)   |  |   |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 8/10/82 to 11/5/82, that (I) (we) lost the deceased on 11/5/82 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |   |  |   |  |   |  |
| 22b. SIGNATURE RENATO ESPINA, M.D.   |  |   |  | DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>           |  | 22c. DATE SIGNED 11/8/82  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)  |  |   |  | 22e. ADDRESS 907 SETON DRIVE, CUMBERLAND, MD 21502  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial   |  | 23b. DATE 11/9/82   |  | 23c. NAME OF CEMETERY OR CREMATORY Hillcrest Burial Park,   |  | 23d. LOCATION CITY OR TOWN COUNTY STATE Cumberland, Allegany Maryland   |  |
| 24. FUNERAL DIRECTOR H. Wayne George CUMBERLAND, MD 21502  |  |   |  | 25a. DATE REC'D. BY REGISTRAR NOV 12 1982   |  | 25b. REGISTRAR'S SIGNATURE  |  |
| GEORGE FUNERAL HOME: 202 GREEN STREET  |  |   |  |   |  |   |  |

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2025 COLLECTION

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR RECORDS. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DHMH-17  
(VRA 15 ME (5))  
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| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH   |  |                      |  |   |  |  |  |  |  | REG. NO. 2 27677   |  |
|---|--|----------------------|--|---|--|--|--|--|--|--|--|
| 1. FOR STATE REGISTRAR  |  |                      |  |   |  |  |  |  |  | 20. DATE KNOWN OF DEATH  |  |
| 1. DECEASED NAME (TYPE OR PRINT) Elizabeth Catherine Hudson   |  |                      |  |   |  |  |  |  |  | 21. DATE OF DEATH ESTIMATED 11 18 82   |  |
| 3. SEX Female   |  | 4. RACE White        |  | 5. DATE OF BIRTH Mar. 10, 1927  |  | 6. AGE (IN YEARS LAST BIRTHDAY) 55 YRS.  |  | 7. IF UNDER 1 YR. MONTHS DAYS HOURS MIN.   |  | 22. DATE PRONOUNCED DEAD 11 18 82  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland  |  |                      |  | 7b. CITIZEN OF WHAT COUNTRY? USA  |  |  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH Allegany Co. MD.                            |  |
| 10. CITY OR TOWN OF DEATH Cumberland  |  |                      |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION 208 New Hampshire Ave. |  |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) none   |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |
| USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |  |                      |  |   |  |  |  |  |  |  |  |
| 13a. STATE Maryland   |  | 13b. COUNTY Allegany |  | 13c. CITY OR TOWN Cumberland  |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS 208 New Hampshire Ave.   |  |  |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST Wilbur M. Hudson  |  |                      |  |   |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Ethel D. Bolinger                                 |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) no   |  |                      |  | 16b. SOCIAL SECURITY NO.  |  |  |  | 17. INFORMANT ADDRESS Mr. R. Wayne Hudson, Cumberland, Brother   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1 DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Myocardial Infarction<br>4100<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.<br>(b) Hypertensive Heart Disease<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)   |  |                      |  |   |  |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                     |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).   |  |                      |  |   |  |  |  |  |  |  |  |
| 19a. DATE OF OPERATION  |  |                      |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?                               |  |  |  |  |  | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |  |                      |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19                            |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)                |  |  |  |  |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  |                      |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)                     |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |  |  |  |  |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . |  |                      |  |   |  |  |  |  |  |  |  |
| ACTUAL SIGNATURE Nicholas Giarritta   |  |                      |  | M.D. Deputy   |  |  |  | MEDICAL EXAMINER DATE SIGNED 11-18-82  |  |  |  |
| EXAMINER'S NAME (TYPE OR PRINT) Nicholas Giarritta  |  |                      |  | ADDRESS Sacred Heart Hospital   |  |  |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial  |  |                      |  | 23b. DATE 11-21-1982  |  | 23c. NAME OF CEMETERY OR CREMATORY Greenmount Cemetery                                       |  | 23d. LOCATION CITY OR TOWN COUNTY STATE Cumberland, Allegany, Md.  |  |  |  |
| 24. FUNERAL DIRECTOR NAME James F. Scarpelli  |  |                      |  |   |  | ADDRESS  |  | 25a. DATE REC'D. BY REGISTRAR 22 NOV 1982  |  |  |  |
|   |  |                      |  |   |  |  |  | 25b. REGISTRAR'S SIGNATURE John J. Connel  |  |  |  |

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Elizabeth Catherine Jackson

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Mar 10, 1907

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 3 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with your death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 2 7 6 7 8

REG. NO.

|  |  |   |  |  |                      |  |
|--|--|---|--|--|----------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>HAZEL MAE JAMES  |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>November 19, 1982 |  | 2b. HOUR<br>6:30 P M |  |
| 3. SEX<br>Female   |  | 4. RACE<br>White  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>June 14, 1911  |                      |  |
| 6. AGE (IN YEARS LAST BIRTHDAY)<br>71 YRS.   |  | 7. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland                                  |  | 8. IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.   |                      |  |
| 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Allegany MD  |  | 10. CITY OR TOWN OF DEATH<br>Cumberland   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Memorial Hospital |                      |  |
| 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Housewife,   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Own Home   |  | 13. STREET ADDRESS<br>Park Ave.  |                      |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Henry -- Winebrenner   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Elizabeth -- Crowe                   |  | 16. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br>No,                         |                      |  |
| 17. SOCIAL SECURITY NO.<br>218-30-0372   |  | 18. INFORMANT<br>Mrs. Dorothy M. Martin, P. O. Box # 88 21524                         |  | ADDRESS Corriganville, Md.   |                      |  |
| 19. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) 4442 SEPTICEMIA.<br>DUE TO, OR AS A CONSEQUENCE OF (b) large intra-abdominal abscess<br>DUE TO, OR AS A CONSEQUENCE OF (c) perforated colon following mesenteric occlusion<br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):<br>acute renal failure post hemo removal by pass |  |   |  |  |                      |  |
| 20a. DATE OF OPERATION<br>10/27/   |  | 20b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br>Occlusion for peripheral vascular |  | 20c. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |                      |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                            |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |                      |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |                      |  |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost<br>saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above. (I) (we) (did) (did not) view the body after death.  |  |   |  |  |                      |  |
| 22b. SIGNATURE<br>[Signature]  |  | DEGREE<br>MD  |  | 22c. DATE SIGNED<br>11/22/82   |                      |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Dr. N. Ranjithan  |  | 22e. ADDRESS<br>Medical Building,<br>Memorial Hospital, Cumberland, MD 21502          |  |  |                      |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial   |  | 23b. DATE<br>11/23/82   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Hillcrest Burial Park, Cumberland, Allegany Maryland                                     |                      |  |
| 24. FUNERAL DIRECTOR<br>H. Wayne George 202 Greene St. Cumberland, Md.   |  | 25a. DATE REC'D. BY REGISTRAR<br>DEC 2 1982   |  | 25b. REGISTRAR'S SIGNATURE<br>John J. Connel   |                      |  |

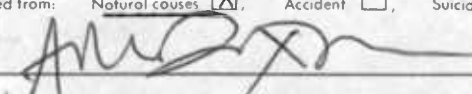
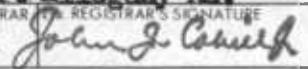
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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL HOME. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITH VITAL RECORDS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

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(VR A15 ME (5))  
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| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE   |  |                      |  |   |  |  |  |  |  | 3 2 2 7 6 7 9   |  |
|--|--|----------------------|--|---|--|--|--|--|--|---|--|
| 1- FOR STATE REGISTRAR   |  |                      |  |   |  |  |  |  |  | REG. NO.  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>JENNIFER KENNEL</b>   |  |                      |  |   |  | 2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> MONTH DAY YEAR <b>11 12 1982</b> |  | 2b. HOUR <b>6:45</b>   |  |   |  |
| 3. SEX <b>Female</b>   |  | 4. RACE <b>white</b> |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR <b>10/5/82</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS <b>1 7</b>                                  |  | 7c. DATE PRONOUNCED DEAD <b>11 12 1982</b>   |  | 7d. HOUR <b>6:45</b>  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>  |  |                      |  | 7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>  |  |  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>     |  | 9. BALTIMORE CITY OR COUNTY OF DEATH <b>Allegany County</b> MD.                     |  |
| 10. CITY OR TOWN OF DEATH <b>Cumberland</b>  |  |                      |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Sacred Heart Hospital</b> |  |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>none</b>  |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |
| 13a. STATE <b>Pennsylvania</b>   |  |                      |  |   |  | 13b. CITY OR TOWN <b>Bedford</b>   |  | 13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 13e. STREET ADDRESS <b>Rt. 1 Box 126</b>  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST <b>Glenn Kennell</b>  |  |                      |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST <b>Janet Knieriem</b>                          |  |  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN) <b>No</b>  |  |                      |  | 16b. SOCIAL SECURITY NO. <b>none</b>  |  |  |  | 17. INFORMANT ADDRESS  |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br><b>7980</b> IMMEDIATE CAUSE (a) <b>Sudden Infant Death Syndrome</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____   |  |                      |  |   |  |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I a.  |  |                      |  |   |  |  |  |  |  |   |  |
| 19a. DATE OF OPERATION   |  |                      |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?   |  |  |  |  |  | 20. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |  |                      |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)                |  |  |  |   |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK  |  |                      |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |  |  |   |  |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . |  |                      |  |   |  |  |  |  |  |   |  |
| ACTUAL SIGNATURE    |  |                      |  | TITLE (SPECIFY) <b>M.D. Assistant</b> MEDICAL EXAMINER  |  |  |  | DATE SIGNED <b>11-13-82</b>  |  |   |  |
| EXAMINER'S NAME (TYPE OR PRINT) <b>Ann M. Dixon, M.D.</b>  |  |                      |  | ADDRESS <b>111 Penn St., Balto., Md. 21201</b>  |  |  |  |  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>  |  |                      |  | 23b. DATE <b>11/15/82</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY <b>Eckhart Cemetery</b>                                   |  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE <b>Eckhart Allegany Md.</b> |   |  |
| 24. FUNERAL DIRECTOR<br>NAME <b>Durst Funeral Home</b>   |  |                      |  | ADDRESS <b>57 Frost Ave. Frostburg, Md. 21532</b>   |  |  |  | 25a. DATE REC'D. BY REGISTRAR <b>NOV 19 1982</b> REGISTRAR'S SIGNATURE  |  |   |  |



RECEIVED

James Henry Jones, Secretary, H.A. 21222  
12/15/82  
Robert Cemetery  
Robert Cemetery, H.A.

none  
James Henry Jones

James Henry Jones, Secretary, H.A. 21222

none

U.S.A.

10/5/82

17

x

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 2 7 6 8 0

REG. NO.



FOR  
STATE  
REGISTRAR

|   |  |  |                  |   |  |  |                           |  |
|---|--|--|------------------|---|--|--|---------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)   |  | FIRST<br>MABEL   | MIDDLE<br>GLADYS | LAST<br>KETZNER   | 2a. DATE OF DEATH MONTH DAY YEAR<br>NOVEMBER 3, 1982 |  | 2b. HOUR<br>3:32<br>A. M. |  |
| 3. SEX<br>Female  |  | 4. RACE<br>White   |                  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>Oct. 20, 1892   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>90<br>YRS.  |                           | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN.   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Ohio   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U. S. A.   |                  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Allegany MD.                                 |                           |  |
| 10. CITY OR TOWN OF DEATH<br>CUMBERLAND   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>MEMORIAL HOSPITAL |                  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Housewife,       |                           | 12b. KIND OF BUSINESS OR INDUSTRY<br>Own Home,   |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br>Maryland  |  |  |                  | 13b. COUNTY<br>Allegany   |  | 13c. CITY OR TOWN<br>Cumberland,   |                           | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                            |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Dennis -- Cronin  |  |  |                  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Mary -- Scanlon  |  |  |                           |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES AND OF UNKNOWN) (IF YES, GIVE WAR OR DATES)<br>No,   |  | 16b. SOCIAL SECURITY NO.<br>216-90-2555  |                  | 17. INFORMANT ADDRESS<br>Mrs. Mary E. Knieriem, 400 Louisiana Ave. Cumberland, Md.  |  |  |                           |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for each condition)<br>PART I: DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a)<br>4292 DUE TO, OR AS A CONSEQUENCE OF<br>Cardiopulmonary Arrest<br>Maximal SVT<br>ASVD - Hypertension<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last:<br>(b) DUE TO, OR AS A CONSEQUENCE OF<br>(c) DUE TO, OR AS A CONSEQUENCE OF<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |  |                  |   |  |  |                           |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |  |                  |   |  |  |                           |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |                  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                           | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |                  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)   |  |  |                           |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)<br>STREET CITY OR TOWN COUNTY STATE                     |                  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |                           |  |
| 22a. I certify that (I) (this hospital) attended the deceased from Nov. 2, 1982, to Nov 3, 1982, that (I) (we) last saw the deceased alive on Nov. 2, 1982, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (do not) view the body after death.   |  |  |                  |   |  |  |                           |  |
| 22b. SIGNATURE<br>Terry Williams  |  |  |                  | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>        |  |  |                           | 22c. DATE SIGNED<br>11-3-82  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>DR. TERRY WILLIAMS   |  |  |                  | 22e. ADDRESS<br>MEMORIAL HOSPITAL MEDICAL BUILDING CUMBERLAND, MARYLAND 21502   |  |  |                           |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial   |  | 23b. DATE<br>11/6/82   |                  | 23c. NAME OF CEMETERY OR CREMATORY<br>St. Patrick's Cem. 21502  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Cumberland, Allegany, Maryland         |                           |  |
| 24. FUNERAL DIRECTOR<br>H. Wayne George 202 Greene St. Cumberland, Md.  |  |  |                  | 25. IF RECEIVED BY REGISTRAR, REGISTRAR'S SIGNATURE<br>NOV 8 1982   |  |  |                           |  |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove and retain pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21202 7 6 8 1  
CERTIFICATE OF DEATH

|   |  |  |   |   |   |   |   |  |  |  |  |
|---|--|--|---|---|---|---|---|--|--|--|--|
| 1. DECEASED-NAME<br>(Type or print) <i>Phoebe</i> First <i>Knoll</i> Middle Last  |  |  | 2a. DATE OF DEATH<br><i>11</i> Month <i>24</i> Day <i>1982</i> Year |   | 2b. HOUR<br><i>1 P</i> M  |   |   |  |  |  |  |
| 3. SEX<br><i>F</i>  |  | 4. RACE<br><i>CAU.</i>   |   | 5. DATE OF BIRTH<br><i>6-13-89</i>  |   | 6. AGE (In years last birthday)<br><i>93</i> YRS.   |   | IF UNDER 1 YEAR<br>MONTHS DAYS               |  | IF UNDER 24 HRS.<br>HOURS MIN                |  |
| 7a. BIRTHPLACE (State or foreign country)<br><i>PA.</i>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><i>U.S.</i>  |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. COUNTY OF DEATH<br><i>ALLEGANY</i> Md.   |   |  |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><i>Cumberland</i>  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><i>ALLEGANY Co. Nursing Home</i> |   | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br><i>House wife</i>  |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><i>None</i>  |   |  |  |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br><i>MD.</i>   |  | 13b. COUNTY<br><i>ALLEGANY</i>   |   | 13c. CITY OR TOWN<br><i>Cumberland</i>  |   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   | 13e. STREET AND NUMBER<br><i>29 Mary St.</i> |  |  |  |
| 14. FATHER'S NAME<br><i>William</i> First <i>Thompson</i> Middle Last   |  |  | 15. MOTHER'S MAIDEN NAME<br><i>Parsons</i> First Middle Last        |   |   |   |   |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or unknown) <i>NO</i>  |  | 16b. SOCIAL SECURITY NO.<br><i>214-32-3605 A</i>   |   | 17. INFORMANT<br><i>Grandchildren</i>   |   | Address<br><i>Cresaptown, Md.</i>   |   |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <i>4413</i> <i>Acute circulatory collapse</i><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Rupture of aortic aneurysm -</i><br>DUE TO, OR AS A CONSEQUENCE OF (c) |  |  |   |   |   |   |   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br><i>Generalized arteriosclerosis</i>   |  |  |   |   |   |   |   |  |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |   | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?            |  |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)  |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. <i>19</i>  |   |   | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |   |   |  |  |  |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Nat while <input type="checkbox"/><br>at work at work  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)                                     |   |   | 21f. LOCATION Street or R.F.D. No. City or Town County State  |   |   |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>November 19, 1980</i> , to <i>November 24, 1982</i> , that (I) (we) last saw the deceased alive on <i>November 24, 1982</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                                    |  |  |   |   |   |   |   |  |  |  |  |
| 22b. SIGNATURE<br><i>Ralph P. Erdly m.d.</i>  |  |  |   |   | DEGREE<br>ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/> |   | 22c. DATE SIGNED<br><i>Nov. 27, 1982</i>  |  |  |  |  |
| 22d. PHYSICIAN'S NAME (Type)<br><i>Ralph P. Erdly m.d.</i>  |  |  |   |   | 22e. ADDRESS<br><i>41 Scott Court, Cumberland Md.</i>   |   |   |  |  |  |  |
| 23a. BURIAL, CREMATION, REINTERMENT<br><i>Buried</i>  |  | 23b. DATE<br><i>11-27-82</i>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><i>Greenmount Cemetery</i>  |   |   | 23d. LOCATION (City or Town) (County) (State)<br><i>Cumberland Allegany Md.</i> |  |  |  |  |
| 24. FUNERAL DIRECTOR<br><i>James F. Scarpelli, Cumberland, Md.</i>  |  |  |   |   | 25a. REC'D BY REGISTRAR<br>DATE <i>NOV 29 1982</i>  |   | 25b. REGISTRAR'S SIGNATURE<br><i>John J. L... ..</i>                            |  |  |  |  |

OFFICE OF THE  
DIRECTOR OF THE  
BUREAU OF THE  
CENSUS

James P. Carroll, Cumberland, Md.  
17-2-12  
Bureau of the Census  
Washington, D.C.

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH-17  
(VR A15 ME (5))  
15M2/80

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1- FOR  
STATE  
REGISTRAR

|   |         |  |  |   |  |   |  |   |  |                          |  |   |  |     |  |                            |  |  |  |   |  |  |  |
|---|---------|--|--|---|--|---|--|---|--|--------------------------|--|---|--|-----|--|----------------------------|--|--|--|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)   |         | FIRST  |  | MIDDLE  |  | LAST  |  | 2b. DATE OF DEATH   |  | KNOWN OF ESTI-MATED      |  | MONTH                                   |  | DAY |  | YEAR                       |  | 2d. HOUR                                     |  |   |  |  |  |
| Farest  |         | S.   |  |   |  | Lancaster   |  | NOV 1   |  | 19                       |  | 82                                      |  | 5A  |  | M                          |  |  |  |   |  |  |  |
| 3. SEX  | 4. RACE | 5. DATE OF BIRTH   |  | 6. AGE (IN YEARS)   |  | IF UNDER 1 YR.  |  | IF UNDER 24 HRS.  |  | 7c. DATE PRONOUNCED DEAD |  | MONTH                                   |  | DAY |  | YEAR                       |  | 2d. HOUR                                     |  |   |  |  |  |
| Male  | White   | Feb. 24, 1911  |  | 71  |  | YRS.  |  |   |  | NOV 1                    |  | 19                                      |  | 82  |  | 743                        |  | M  |  |   |  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   |         | 7b. CITIZEN OF WHAT COUNTRY?                             |  | 8. MARRIED  |  | NEVER MARRIED   |  | 9. BALTIMORE CITY OR COUNTY OF DEATH  |  |                          |  |   |  |     |  |                            |  |  |  |   |  |  |  |
| Maryland  |         | U.S.A.   |  | WIDOWED   |  | DIVORCED  |  | Allegany  |  |                          |  |   |  |     |  |                            |  |  |  |   |  |  |  |
| 10. CITY OR TOWN OF DEATH   |         | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) |  | 12b. KIND OF BUSINESS OR INDUSTRY                                   |  |   |  |                          |  |   |  |     |  |                            |  |  |  |   |  |  |  |
| Rawlings  |         | Rt. 3 Rawlings   |  | Retired   |  | Farmer  |  |   |  |                          |  |   |  |     |  |                            |  |  |  |   |  |  |  |
| 13a. STATE  |         | 13b. COUNTY  |  | 13c. CITY OR TOWN   |  | 13d. INSIDE CITY LIMITS?  |  | 13e. STREET ADDRESS   |  |                          |  |   |  |     |  |                            |  |  |  |   |  |  |  |
| MD  |         | Allegany   |  | Rawlings  |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | Rt 3 Box 203 Rawlings, Md.  |  |                          |  |   |  |     |  |                            |  |  |  |   |  |  |  |
| 14. FATHER'S NAME   |         | MIDDLE   |  | LAST  |  | 15. MOTHER'S MAIDEN NAME  |  | MIDDLE  |  | LAST                     |  |   |  |     |  |                            |  |  |  |   |  |  |  |
| John  |         | W.   |  | Lancaster   |  | Ruth  |  | Waxler  |  |                          |  |   |  |     |  |                            |  |  |  |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)  |         | 16b. SOCIAL SECURITY NO.                                 |  | 17. INFORMANT   |  | ADDRESS   |  |   |  |                          |  |   |  |     |  |                            |  |  |  |   |  |  |  |
| No  |         | No   |  | 212 18 1850   |  | Norma L. Gordon   |  | P.O.Box 21  |  | Bruceton                 |  |   |  |     |  |                            |  |  |  |   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)   |         |  |  |   |  |   |  |   |  |                          |  |   |  |     |  |                            |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |   |  |  |  |
| PART 1 DEATH WAS CAUSED BY:   |         |  |  |   |  |   |  |   |  |                          |  |   |  |     |  |                            |  |  |  |   |  |  |  |
| IMMEDIATE CAUSE (a) <u>probably arteriosclerotic</u>  |         |  |  |   |  |   |  |   |  |                          |  |   |  |     |  |                            |  |  |  |   |  |  |  |
| 4140 DUE TO, OR AS A CONSEQUENCE OF   |         |  |  |   |  |   |  |   |  |                          |  |   |  |     |  |                            |  |  |  |   |  |  |  |
| Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) <u>Heart disease</u>  |         |  |  |   |  |   |  |   |  |                          |  |   |  |     |  |                            |  |  |  |   |  |  |  |
| DUE TO, OR AS A CONSEQUENCE OF (c)  |         |  |  |   |  |   |  |   |  |                          |  |   |  |     |  |                            |  |  |  |   |  |  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).   |         |  |  |   |  |   |  |   |  |                          |  |   |  |     |  |                            |  |  |  |   |  |  |  |
| 19a. DATE OF OPERATION  |         |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?             |  |   |  |   |  |                          |  |   |  |     |  |                            |  |  |  | 20. AUTOPSY?  |  |  |  |
|   |         |  |  |   |  |   |  |   |  |                          |  |   |  |     |  |                            |  |  |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |         |  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR                  |  |   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) |  |                          |  |   |  |     |  |                            |  |  |  |   |  |  |  |
|   |         |  |  | P.M. 19   |  |   |  |   |  |                          |  |   |  |     |  |                            |  |  |  |   |  |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK   |         |  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)   |  |   |  | 21f. LOCATION STREET  |  |                          |  | CITY OR TOWN                            |  |     |  | COUNTY                     |  |  |  | STATE   |  |  |  |
|   |         |  |  |   |  |   |  |   |  |                          |  |   |  |     |  |                            |  |  |  |   |  |  |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . |         |  |  |   |  |   |  |   |  |                          |  |   |  |     |  |                            |  |  |  |   |  |  |  |
| ACTUAL SIGNATURE  |         |  |  | Francisco Reyes M.D.  |  |   |  |   |  |                          |  | TITLE (SPECIFY) Deputy Medical Examiner |  |     |  | DATE SIGNED 10-1-82        |  |  |  |   |  |  |  |
| EXAMINER'S NAME (TYPE OR PRINT)   |         |  |  | Francisco Reyes   |  |   |  |   |  |                          |  | ADDRESS 900 Seton Dr. Cumberland, Md    |  |     |  | 21502                      |  |  |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)   |         |  |  | 23b. DATE   |  |   |  | 23c. NAME OF CEMETERY OR CREMATORY  |  |                          |  | 23d. LOCATION CITY OR TOWN              |  |     |  | COUNTY                     |  |  |  | STATE   |  |  |  |
| Burial  |         |  |  | 4 Nov 1982  |  |   |  | Waxler Cemetery   |  |                          |  | Rawlings                                |  |     |  | Allegany Md.               |  |  |  |   |  |  |  |
| 24. FUNERAL DIRECTOR NAME   |         |  |  | Allen M. Rotruck  |  |   |  | 85 S. Main Keyser, W. Va.   |  |                          |  | 25a. DATE REC'D. BY REGISTRAR           |  |     |  | 25b. REGISTRAR'S SIGNATURE |  |  |  |   |  |  |  |
|   |         |  |  |   |  |   |  |   |  |                          |  | NOV-4 1982                              |  |     |  | John J. Conner             |  |  |  |   |  |  |  |

COX COLON 11110

Report  
Date  
Time  
Place  
Subject  
Remarks  
Signature  
Date

1. Cox Colon 11110  
2. Cox Colon 11110  
3. Cox Colon 11110  
4. Cox Colon 11110  
5. Cox Colon 11110  
6. Cox Colon 11110  
7. Cox Colon 11110  
8. Cox Colon 11110  
9. Cox Colon 11110  
10. Cox Colon 11110

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 10 days of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of a

MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |   |  |   |   |   |   |  |   |
|--|--|---|--|---|---|---|---|--|---|
| 1. FOR<br>STATE<br>REGISTRAR   |  |   |  |   | REG. NO.  |   |   |  |   |
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>EMMONS WILLIAM LANDIS</b>   |  |   |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>NOVEMBER 11, 1982</b>                                 |   |   | 2b. HOUR<br><b>5:58A<sub>M</sub></b>   |   |
| 3. SEX<br><b>M</b>   |  | 4. RACE<br><b>W</b>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>Oct. 23, 1899</b>  |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>83</b> YRS.                         |   | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN.   |   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Pennsylvania</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U S A</b>  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>ALLEGANY COUNTY, MD.</b>       |   |  |   |
| 10. CITY OR TOWN OF DEATH<br><b>Cumberland</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>SACRED HEART HOSPITAL</b> |  |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Laborer</b>              |   |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Farm</b>   |   |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |  |   |  |   | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   | 13e. STREET ADDRESS<br><b>Route 2, Box 683</b>      |  |   |
| 13a. STATE<br><b>Maryland</b>  |  | 13b. COUNTY<br><b>Allegany</b>  |  | 13c. CITY OR TOWN<br><b>Cumberland</b>  |   |   |   |  |   |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>David Conrad Landis</b>   |  |   |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Ida Idella Foust</b>                        |   |   |  |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>218 30 0745</b>   |  | 17. INFORMANT ADDRESS<br><b>Zella Landis, as above</b>  |   |   |   |  |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Carcinoma Rectum - metastases</b><br><b>1541</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. |  |   |  |   |   |   |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>2-3 months</b> |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)   |  |   |  |   |   |   |   |  |   |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |   |   |   |  |   |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |   |   |   |  |   |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>Nov. 9, 1982</b> , to <b>Nov. 11, 1982</b> , that (I) (we) lost<br>saw the deceased alive on 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death.  |  |   |  |   |   |   |   |  |   |
| 22b. SIGNATURE<br><b>L.R. Miles Jr MD</b>  |  |   |  |   | 22c. DATE SIGNED<br><b>11.22.82</b>   |   |   | 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>L.R. MILES, JR MD</b>  |   |
| 22e. ADDRESS   |  |   |  |   |   |   |   |  |   |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>  |  | 23b. DATE<br><b>11/13/82</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Zion Memorial Cemetery</b>   |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Cumberland, Md</b>       |   |  |   |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>HAFER FUNERAL HOME; 58 FROST ST. FROSTBURG, MD.</b>   |  |   |  |   | 25a. DATE REC'D. BY REGISTRAR<br><b>NOV 24 1982</b>   |   | 25b. REGISTRAR'S SIGNATURE<br><b>John J. Carver</b> |  |   |

2-12-54  
 WILLIAM JAMES  
 NOVEMBER 11, 1927  
 83  
 004.00, 1954  
 U.S.A.  
 SAGGED HEART HOSPITAL  
 LABORER  
 1000 S. 2nd St.  
 218 TO 225, 1st St. S., above  
 1st St. S.

20% COLT  
 20% COLT  
 20% COLT



11/13/52  
 11/13/52  
 11/13/52



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF, MEDICAL EXAMINER, ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED. WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH-17  
(VR A15 ME (5))  
15M 2/80

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

|  |         |  |  |  |  |   |  |                     |  |                          |  |   |  |
|--|---------|--|--|--|--|---|--|---------------------|--|--------------------------|--|---|--|
| FOR<br>STATE<br>REGISTRAR  |         | 2 7 6 8 4  |  |  |  |   |  |                     |  |                          |  |   |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |         | FIRST  |  | MIDDLE   |  | LAST  |  | 2b. DATE OF DEATH   |  | 2c. DATE OF ESTI-MATED   |  | 2d. HOUR  |  |
| Alice M. Larson  |         |  |  |  |  |   |  | 11/25/82            |  | 10:10                    |  | A.M.  |  |
| 3. SEX   | 4. RACE | 5. DATE OF BIRTH   |  | 6. AGE (IN YEARS)  |  | IF UNDER 1 YR.  |  | IF UNDER 24 HRS.    |  | 7c. DATE PRONOUNCED DEAD |  | 7d. HOUR  |  |
| Female   | White   | Oct. 4, 1930   |  | 52 YRS   |  |   |  |                     |  | 11/25/82                 |  | 10:10 A.M.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |         | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH                                |  |                     |  |                          |  |   |  |
| MD   |         | USA  |  |  |  | Allegany MD   |  |                     |  |                          |  |   |  |
| 10. CITY OR TOWN OF DEATH  |         | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)  |  | 12b. KIND OF BUSINESS OR INDUSTRY                                   |  |                     |  |                          |  |   |  |
| Cumberland   |         | 725 Maryland Ave.  |  | Housewife  |  | Own home  |  |                     |  |                          |  |   |  |
| 13a. STATE   |         | 13b. CITY OR TOWN  |  | 13c. CITY OR TOWN  |  | 13d. INSIDE CITY LIMITS?  |  | 13e. STREET ADDRESS |  | 21502                    |  |   |  |
| MD   |         | Allegany   |  | Cumberland   |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 725 Maryland Ave.   |  |                          |  |   |  |
| 14. FATHER'S NAME  |         | MIDDLE   |  | LAST   |  | 15. MOTHER'S MAIDEN NAME  |  | MIDDLE              |  | LAST                     |  |   |  |
| Travis   |         | W.   |  | Smith  |  | Alice   |  | M.                  |  | Martin                   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)  |         | 16b. SOCIAL SECURITY NO.   |  | 17. INFORMANT  |  | ADDRESS   |  |                     |  |                          |  |   |  |
| No   |         | 215-26-6437  |  | Florence Reed Cumberland, MD   |  | 21502   |  |                     |  |                          |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1 DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>CONGESTIVE HEART FAILURE</u><br>4241<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>AORTIC STENOSIS</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>ATRIAL FIBRILLATION</u><br>PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). |         |  |  |  |  |   |  |                     |  |                          |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>SCARCE<br>YES |  |
| 19a. DATE OF OPERATION   |         | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |  | 20. AUTOPSY?   |  |   |  |                     |  |                          |  |   |  |
|  |         |  |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |   |  |                     |  |                          |  |   |  |
| 21a. EXTERNAL CAUSE WAS<br>UNDERLYING <input type="checkbox"/> OR<br>CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |         | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)  |  |   |  |                     |  |                          |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |         | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |   |  |                     |  |                          |  |   |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . |         |  |  |  |  |   |  |                     |  |                          |  |   |  |
| ACTUAL SIGNATURE   |         | TITLE (SPECIFY)  |  | DATE SIGNED  |  |   |  |                     |  |                          |  |   |  |
| Paul Snow M. D.  |         | M.D. Asst. Asst. Medical Examiner  |  | 11/25/82   |  |   |  |                     |  |                          |  |   |  |
| EXAMINER'S NAME<br>(TYPE OR PRINT)   |         | ADDRESS  |  |  |  |   |  |                     |  |                          |  |   |  |
| Paul Snow M. D.  |         | Memorial Hospital, Cumberland MD   |  |  |  |   |  |                     |  |                          |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)   |         | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE                          |  |                     |  |                          |  |   |  |
| Burial   |         | Nov 28, 1982   |  | Sunset Memorial P.   |  | Cumberland Allegany MD  |  |                     |  |                          |  |   |  |
| 24. FUNERAL DIRECTOR<br>NAME   |         | ADDRESS  |  | 25a. DATE REC'D. BY REGISTRAR  |  | 25b. REGISTRAR'S SIGNATURE  |  |                     |  |                          |  |   |  |
| William G. Kight   |         | Cumberland, MD   |  | NOV 29 1982  |  | John J. Carver  |  |                     |  |                          |  |   |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be retained by the funeral director within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  | 8 2 2 7 6 8 5   |  |  |  |
|--|--|--|--|---|--|--|--|
| 1. FOR STATE REGISTRAR   |  |  |  | REG. NO.  |  |  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT) FIRST MIDDLE LAST<br>ELWOOD NMI LAYMAN   |  |  |  | 2a. DATE OF DEATH MONTH DAY YEAR<br>NOVEMBER 20, 1982   |  | 2b. HOUR<br>2:45 A.M.  |  |
| 3. SEX<br>Male   |  | 4. RACE<br>White   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>July 22, 1924   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>58 YRS.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>ALLEGANY COUNTY MD.  |  |
| 10. CITY OR TOWN OF DEATH<br>Cumberland  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>SACRED HEART HOSPITAL |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Professor   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>college   |  |
| 13a. STATE<br>Maryland   |  |  |  | 13b. COUNTY<br>Allegany   |  | 13c. CITY OR TOWN<br>Cumberland  |  |
| 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  |  |  | 13e. STREET ADDRESS<br>420 S. Allegany St.  |  |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Albert Layman  |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Letitia Friend   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>Yes  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>W.W. 2 220-16-6288  |  | 17. INFORMANT ADDRESS<br>Harold Ellerholz, Cumberland, Md.  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cardiogenic Shock</u><br>4100<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>Pulm Edema &amp; Cong Heart Failure</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>Acute Myocardial Infarction</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>Trippe Venal Coronary Artery Disease</u> |  |  |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>3 days<br>6 days   |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>11/14/82</u> 19 <u>82</u> to <u>Nov 20</u> 19 <u>82</u> , that (I) (we) lost<br>saw the deceased alive on <u>Nov 19</u> 19 <u>82</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above. (If (we) (did) (did not) view the body after death.)  |  |  |  |   |  |  |  |
| 22b. SIGNATURE<br><u>Chang Oh, M.D.</u>  |  |  |  | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>        |  | 22c. DATE SIGNED   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>CHANG OH, M.D.  |  |  |  | 22e. ADDRESS<br>48 TARN TERRACE, FROSTBURG, M.D. 21532  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial  |  | 23b. DATE<br>Nov. 23 '82   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Mt. Zion Cemetery   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Garrett County, Md.  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>DURST FUNERAL HOME   |  |  |  | 57 FROST AVENUE<br>FROSTBURG, MD. 21532   |  | 25a. DATE REC'D. BY REGISTRAR<br>NOV 26 1982   |  |
|  |  |  |  | 25b. REGISTRAR'S SIGNATURE<br><u>John J. Conner</u>   |  |  |  |

Page 4

STATE OF ALABAMA

JANUARY

1901

ELWOOD

John

White

July 22, 1901

50

ALLIANCE COUNTY

Marriage

...

JACKSON HART HOSPITAL

Outpatient

College

1900 . January 22

Quincy, Mo.

Marriage

Bylaws

Article

Article

Article

Yes. W. M. S. 1900-1901. No. 1. Quincy, Mo.



1900-1901. No. 1. Quincy, Mo.

Quincy, Mo.

Quincy, Mo.

Quincy, Mo.

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1b. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 2 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DHMH - 17  
(VRA 15 ME (5))  
15M 2/80

MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH   |  |  |  |  |  |  |  |  |  | REG. NO. 2 27686  |  |
|---|--|--|--|--|--|--|--|--|--|---|--|
| 1- FOR STATE REGISTRAR  |  |  |  |  |  |  |  |  |  | 7a. DATE KNOWN OF DEATH   |  |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST<br><b>CARLTON IANSWELL LEASE</b>   |  |  |  |  |  |  |  |  |  | 7b. HOUR 7 A M  |  |
| 3. SEX MALE 4. RACE WHITE 5. DATE OF BIRTH MONTH DAY YEAR March 21 1915 6. AGE (IN YEARS LAST BIRTHDAY) 67 YRS. 7c. DATE PRONOUNCED DEAD 11 30 19 82 7d. HOUR 8 A M   |  |  |  |  |  |  |  |  |  | 7e. DATE KNOWN OF DEATH MONTH DAY YEAR 11 30 19 82 7f. HOUR 8 A M |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland 7b. CITIZEN OF WHAT COUNTRY? U.S.A. 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> 9. BALTIMORE CITY OR COUNTY OF DEATH ALLEGANY MD.   |  |  |  |  |  |  |  |  |  |   |  |
| 10. CITY OR TOWN OF DEATH CUMBERLAND 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 225 Baltimore Avenue 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired Staff Sgt 12b. KIND OF BUSINESS OR INDUSTRY Military  |  |  |  |  |  |  |  |  |  |   |  |
| USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MARYLAND 13b. COUNTY ALLEGANY 13c. CITY OR TOWN CUMBERLAND 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> 13e. STREET ADDRESS 225 BALTIMORE AVENUE  |  |  |  |  |  |  |  |  |  |   |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST William Branson Lease 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Hazel Whisner  |  |  |  |  |  |  |  |  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) YES 16b. SOCIAL SECURITY NO. WW11 214-05-7999 17. INFORMANT William Lease ADDRESS #1 Wayne Avenue Jeannette, Pa 15644  |  |  |  |  |  |  |  |  |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1 DEATH WAS CAUSED BY:<br>4100 IMMEDIATE CAUSE (a) Heart Failure - Myocardial Inf. DUE TO, OR AS A CONSEQUENCE OF<br>(b) Arteriosclerotic Heart Disease. DUE TO, OR AS A CONSEQUENCE OF<br>(c) Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.  |  |  |  |  |  |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                      |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).   |  |  |  |  |  |  |  |  |  |   |  |
| 19a. DATE OF OPERATION 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |  |  |  |  |  |  |  |  |   |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)  |  |  |  |  |  |  |  |  |  |   |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |  |  |  |  |  |  |  |  |  |   |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . |  |  |  |  |  |  |  |  |  |   |  |
| ACTUAL SIGNATURE Nicholas Giarritta TITLE (SPECIFY) Deputy MEDICAL EXAMINER DATE SIGNED 11-30-82  |  |  |  |  |  |  |  |  |  |   |  |
| EXAMINER'S NAME (TYPE OR PRINT) NICHOLAS GIARRITTA ADDRESS 900 Seton Drive Cumber.  |  |  |  |  |  |  |  |  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial 23b. DATE Dec 3, 1982 23c. NAME OF CEMETERY OR CREMATORY Hillcrest Burial Park 23d. LOCATION CITY OR TOWN COUNTY STATE Cumberland Allegany Maryland  |  |  |  |  |  |  |  |  |  |   |  |
| 24. FUNERAL DIRECTOR NAME ADDRESS 404 Decatur St Silcox-Merritt Funeral Service, Cumberland, Md 25a. DATE REC'D. BY REGISTRAR DEC 6, 1982 25b. REGISTRAR'S SIGNATURE John J. Lough  |  |  |  |  |  |  |  |  |  |   |  |

BP

REPORT OF THE AGENT IN CHARGE

DATE OF REPORT: 12/15/1962

TO: DIRECTOR, FBI

FROM: SAC, BALTIMORE

SUBJECT: [REDACTED]

RE: [REDACTED]

REFERENCE: [REDACTED]

CHARACTER OF CASE: [REDACTED]

CLASSIFICATION: [REDACTED]

STATUS: [REDACTED]

DETAILS: [REDACTED]

ANALYSIS: [REDACTED]

CONCLUSIONS: [REDACTED]

RECOMMENDATIONS: [REDACTED]

ADMINISTRATIVE: [REDACTED]

[REDACTED]

APPROVED: [REDACTED]

DATE: 12/15/1962

INITIALS: [REDACTED]

40A REPORT OF

ALBION-Service Bureau, Baltimore, Md.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and certified by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |   |  |   |  |  |   |  |  | REG. NO. 8 2 2 7 6 8 7 |  |
|--|--|---|--|---|--|--|---|--|--|------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>RALPH MILTON LINTZ</b>  |  |   |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>November 21, 1982</b>  |  |   | 2b. HOUR<br><b>2:06 PM</b>                                       |  |                        |  |
| 3. SEX<br><b>Male</b>  |  | 4. RACE<br><b>White</b>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>Nov. 27, 1922</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>59</b> YRS.  |   | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN. |  |                        |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Pennsylvania</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Allegany</b> MD.                                  |   |  |  |                        |  |
| 10. CITY OR TOWN OF DEATH<br><b>Cumberland</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Memorial Hospital</b> |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Retired U.S. Gov.</b> |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Postal Dept.</b>         |  |                        |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE <b>Md.</b> 13b. COUNTY <b>Allegany</b> 13c. CITY OR TOWN <b>Cumberland</b>  |  |   |  |   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  | 13e. STREET ADDRESS<br><b>11 H Fort Cumberland Homes</b>  |  |  |                        |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Michael Lintz</b>   |  |   |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Freda Kommel</b>   |  |   |  |  |                        |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>Yes</b>   |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>War II 192-12-9101</b>  |  | 17. INFORMANT ADDRESS<br><b>Mrs. Norma Jean Lintz, Cumberland, Md. Wife</b>   |  |  |   |  |  |                        |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br><b>4254 Ventricular Tachycardia.</b><br>IMMEDIATE CAUSE (a) <b>4254</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>Cardiomyopathy</b><br>DUE TO, OR AS A CONSEQUENCE OF (c) <b>Arterio Sclerosis, Severe.</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |   |  |   |  |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |                        |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>Hypertension, chronic renal failure, failure of Varicella Vaccines, recent peritonitis.</b>  |  |   |  |   |  |  |   |  |  |                        |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |   | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |  |                        |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |   |  |  |                        |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |   |  |  |                        |  |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |   |  |   |  |  |   |  |  |                        |  |
| 22b. SIGNATURE <b>[Signature]</b> DEGREE   |  |   |  |   | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  |   | 22c. DATE SIGNED<br><b>11/22/82</b>                              |  |                        |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>N.A. Ranjithan MD.</b>   |  |   |  |   | 22e. ADDRESS<br><b>Medical Building, Memorial Hospital, Cumberland, MD 21502</b>   |  |   |  |  |                        |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>   |  | 23b. DATE<br><b>Nov. 24, 1982</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Rocky Gap Cemetery</b>   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Near Flintstone Md. Allegany</b>            |   |  |  |                        |  |
| 24. FUNERAL DIRECTOR<br>NAME <b>James F. Scarpelli, Cumberland, Md.</b> ADDRESS  |  |   |  |   | 25a. DATE REC'D. BY REGISTRAR (REGISTERAR'S SIGNATURE)<br><b>NOV 26 1982 John J. Conner</b>  |  |   |  |  |                        |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| FOR STATE REGISTRAR   |  |  |  | STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |   |  | REG. NO. 8 2 2 7 6 8 8   |  |  |  |
|---|--|--|--|---|--|---|--|--|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>Betty Jane Lueck   |  |  |  | 2a. DATE OF DEATH MONTH DAY YEAR<br>11 19 1982  |  |   |  | 2b. HOUR<br>1405 M   |  |  |  |
| 3. SEX<br>female  |  | 4. RACE<br>white   |  | 5. DATE OF BIRTH MONTH DAY YEAR<br>7-18-26  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>56 YRS.  |  | IF UNDER 1 YEAR<br>MONTHS DAYS   |  | IF UNDER 74 HRS<br>HOURS MIN.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Cumberland Md.   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Alleg. MD.  |  |  |  |  |  |
| 10. CITY OR TOWN OF DEATH<br>Cumberland   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Sacred Heart Hospital |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Housewife                   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>In Own Home   |  |  |  |
| 13a. STATE<br>MD.   |  | 13b. COUNTY<br>Alleg.  |  | 13c. CITY OR TOWN<br>Cumberland   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br>319 Williams Street   |  |  |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>Raymond Trexler  |  |  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>Helen Gordon  |  |   |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>no  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>218-16-4922   |  | 17. INFORMANT ADDRESS<br>Mr. Howard F. Lueck, Cumberland, Md. Husband   |  |   |  |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>INTRACEREBRAL HEMORRHAGE</u><br><u>4292</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>ASCVD</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>NO</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |  |  |   |  |   |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><u>HRS</u><br><u>YRS</u> |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |  |  |   |  |   |  |  |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                       |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)   |  |   |  |  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |  |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>NOV 19 1982</u> to <u>NOV 19 1982</u> that (I) (we) last saw the deceased alive on <u>NOV 19 1982</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If not, add and do not "view the body after death")   |  |  |  |   |  |   |  |  |  |  |  |
| 22b. SIGNATURE<br><u>[Signature]</u>  |  |  |  | DEGREE<br><u>MD</u>   |  |   |  | 22c. DATE SIGNED<br><u>11/19/82</u>  |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Bruce D. Behounek, MD  |  |  |  | 22e. ADDRESS<br>BHG - SACRED HEART HOSPITAL   |  |   |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial   |  | 23b. DATE<br>11-22-1982  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>St. Marys Cemetery  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Cumberland, Allegany, Md.                         |  |  |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>SCARPELLI FUNERAL HOME  |  |  |  | 108 VIRGINIA AVE.<br>ADDRESS<br>CUMBERLAND, MD 21502  |  | 25a. DATE REC'D. BY REGISTRAR<br>NOV 24 1982  |  | 25b. REGISTRAR'S SIGNATURE<br><u>[Signature]</u>   |  |  |  |

BP



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE  |  |   |  |  | 8 2 2 7 6 8 9 |  |
|---|--|---|--|--|---------------|--|
| 1. FOR<br>STATE<br>REGISTRAR  |  |   | CERTIFICATE OF DEATH   |  |               |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)   |  |   | 2a. DATE OF DEATH  |  |               |  |
| ELMER EDWARD MANKAMYER  |  |   | NOVEMBER 12 1982   |  |               |  |
| 3. SEX<br>MALE  |  |   | 2b. HOUR<br>2025 M   |  |               |  |
| 4. RACE<br>WHITE  |  |   | 5. DATE OF BIRTH<br>AUG 30 1916  |  |               |  |
| 6. AGE (IN YEARS LAST BIRTHDAY)<br>66 YRS.  |  |   | 7. IF UNDER 1 YEAR<br>MONTHS DAYS  |  |               |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>PENNA.   |  |   | 7b. CITIZEN OF WHAT COUNTRY?<br>USA  |  |               |  |
| 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>   |  |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>ALLEGANY MD.   |  |               |  |
| 10. CITY OR TOWN OF DEATH<br>CUMBERLAND   |  |   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>MEMORIAL HOSPITAL |  |               |  |
| 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>RETIRED WESTERN MD. RAILROAD  |  |   | 12b. KIND OF BUSINESS OR INDUSTRY  |  |               |  |
| 13a. STATE<br>MARYLAND  |  |   | 13b. COUNTY<br>ALLEGANY  |  |               |  |
| 13c. CITY OR TOWN<br>LAVALE   |  |   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                |  |               |  |
| 14. FATHER'S NAME<br>CHRIST   |  |   | 15. MOTHER'S MAIDEN NAME<br>MARTHA MURRAY  |  |               |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>YES, NO OR UNKNOWN<br>NO  |  |   | 16b. SOCIAL SECURITY NO.<br>181-14-3767  |  |               |  |
| 17. INFORMANT<br>HAZEL MANKAMYER  |  |   | ADDRESS<br>MARYLAND 2150<br>16 NATIONAL HIGHWAY LAVALE   |  |               |  |
| 18. CAUSE OF DEATH (Enter only one cause per line or (a), (b), or (c))<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cardiovascular Arrest</u><br>4292<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last:<br>(b) <u>myocardial infarction + CAD</u><br>(c) <u>ASVD</u>       |  |   |  |  |               |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |   |  |  |               |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                    |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |               |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                          |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)       |               |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)<br>May 23 74 |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE<br>Nov-12 82                       |               |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>Oct. 21 1982</u> to <u>Nov-12 1982</u> , that (I) (we) lost <u>the deceased</u> alive on <u>Nov-12 1982</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If we) did (did not) view the body after death. |  |   |  |  |               |  |
| 22b. SIGNATURE<br><u>William M.D.</u>   |  | DEGREE<br><u>M.D.</u>   |  | 22c. DATE SIGNED<br>11-15-82   |               |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>TEWILLIAMS, M.D.   |  | 22e. ADDRESS<br>MEMORIAL MED. CTR., CUMB., MD.                                      |  |  |               |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>BURIAL   |  | 23b. DATE<br>NOV 16, 1982   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>GREENVILLE PA.                                 |               |  |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>RED POCAHONTAS SOMERSET PA.   |  | 25a. DATE REC'D. BY REGISTRAR<br>NOV 16 1982  |  |  |               |  |
| 24. FUNERAL DIRECTOR<br>SILCOX-MERRITT FUNERAL SERVICE  |  | ADDRESS<br>CUMBERLAND MD.   |  |  |               |  |



OVER

WATER



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |  | 8 2 2 7 6 9 0   |  |  |   |
|---|--|--|--|---|--|--|---|
| 1. FOR STATE REGISTRAR  |  |  |  | REG. NO.  |  |  |   |
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>HARRY WASHINGTON MATTHEWS  |  |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>NOVEMBER 17, 1982  |  | 2b. HOUR<br>7:30 A.M.  |   |
| 3. SEX<br>Male  |  | 4. RACE<br>White   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>Jan. 25, 1901   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>81 YRS.   |   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>ALLEGANY COUNTY MD.  |   |
| 10. CITY OR TOWN OF DEATH<br>Cumberland   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>SACRED HEART HOSPITAL |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Engineering Dept.   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Fibres Indus try  |   |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br>W.Va.   |  |  |  | 13b. COUNTY<br>Mineral  |  | 13c. CITY OR TOWN<br>New Creek   |   |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Henry W. Matthews   |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Susan Ann Geary  |  |  |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>None  |  | 17. INFORMANT ADDRESS<br>Mrs. Myrtle Matthews, New Creek, W. Va.  |  |  |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>4920 IMMEDIATE CAUSE (a) <u>Respiratory Failure</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>Chronic Obstructive Pulmonary dis</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>Emphysema</u>   |  |  |  |   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>5 day<br>20 y |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>Cor Pulmonale</u>   |  |  |  |   |  |  |   |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)   |  |  |   |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |   |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>1975</u> , 19____, to <u>11/17/82</u> , 19____, that (I) (we) last saw the deceased alive on <u>11/15/82</u> , 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |   |  |  |   |
| 22b. SIGNATURE<br><u>[Signature]</u>  |  |  |  | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>        |  | 22c. DATE SIGNED<br>11-17-82   |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><u>[Name]</u>  |  |  |  | 22e. ADDRESS<br>BMG 912 SETON DRIVE, CUMBERLAND, MD. 21502  |  |  |   |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial  |  | 23b. DATE<br>Nov. 20, 1982   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Philos Cemetery   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Westernport Allegany Md.   |   |
| 25a. DISPOSED BY REGISTRY<br>MARKWOOD FUNERAL HOME: KEYSER WA 26726   |  |  |  | 25b. DATE OF REGISTRY<br>NOV 22 1982  |  |  |   |

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RECEIVED IN 1960

RECEIVED IN 1960

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5. IF THE DECEASED IS A MEMBER OF THE U.S. ARMY, NAVY, AIR FORCE, MARINE CORPS, OR COAST GUARD, GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

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| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH   |  |                         |  |   |  |   |  |  |  | REG. NO. 2 27691  |  |                             |  |
|---|--|-------------------------|--|---|--|---|--|--|--|---|--|-----------------------------|--|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST<br><b>J. Patrick Mc Mullen</b>   |  |                         |  |   |  |   |  |  |  | 2a. DATE KNOWN OF DEATH MONTH DAY YEAR<br><b>11-15 19 82</b>                |  |                             |  |
| 3. SEX<br><b>Male</b>   |  | 4. RACE<br><b>White</b> |  | 5. DATE OF BIRTH MONTH DAY YEAR<br><b>March 17, 1937 45 YRS.</b>  |  | 6. AGE (IN YEARS) (LAST BIRTHDAY) MONTHS DAYS HOURS MIN.<br><b>45 YRS.</b>    |  | 7c. DATE PRONOUNCED DEAD MONTH DAY YEAR<br><b>Nov. 15 19 82</b>  |  | 2b. HOUR<br><b>7:15 a</b>   |  |                             |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>  |  |                         |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  |   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Allegany</b> MD.                 |  |                             |  |
| 10. CITY OR TOWN OF DEATH<br><b>Cumberland</b>  |  |                         |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>211 Schley Street</b> |  |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Vice President</b>   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Construction Co.</b>                |  |                             |  |
| 13a. STATE<br><b>Maryland</b>   |  |                         |  | 13b. CITY OR TOWN<br><b>Allegany</b>  |  | 13c. CITY OR TOWN<br><b>Cumberland</b>  |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  | 13e. STREET ADDRESS<br><b>211 Schley St.</b>                                |  |                             |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br><b>Richard F. Mc Mullen</b>  |  |                         |  |   |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><b>Catherine Long</b>           |  |  |  |   |  |                             |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)<br><b>no</b>   |  |                         |  | 16b. SOCIAL SECURITY NO.<br><b>220-44-6798</b>  |  | 17. INFORMANT ADDRESS<br><b>Mrs. Eithne Mc Mullen, Cumberland, Wife</b>       |  |  |  |   |  |                             |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Myocardial Infarction</b><br>4100<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.<br>(b) <b>Coronary Artery Disease</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a). |  |                         |  |   |  |   |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                |  |                             |  |
| 19a. DATE OF OPERATION  |  |                         |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?   |  |   |  | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |   |  |                             |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |  |                         |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) |  |  |  |   |  |                             |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK   |  |                         |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)   |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE                                |  |  |  |   |  |                             |  |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .                                 |  |                         |  |   |  |   |  |  |  |   |  |                             |  |
| ACTUAL SIGNATURE <b>Nicholas Giarritta</b>  |  |                         |  | TITLE (SPECIFY) <b>Deputy</b> M.D.  |  |   |  | MEDICAL EXAMINER   |  |   |  | DATE SIGNED <b>11-15-82</b> |  |
| EXAMINER'S NAME (TYPE OR PRINT) <b>Dr. Nicholas Giarritta</b>   |  |                         |  | ADDRESS <b>Sacred Heart Hospital, Cumberland, Md.</b>   |  |   |  |  |  |   |  |                             |  |
| 23a. BURIAL, CREMATION, REMOVAL SPECIFY<br><b>Burial</b>  |  |                         |  | 23b. DATE<br><b>11-18-1982</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>SS. Peter &amp; Paul Cem.</b>        |  |  |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br><b>Cumberland, Allegany, Md.</b> |  |                             |  |
| 24. FUNERAL DIRECTOR NAME<br><b>James F. Scarpelli, Cumberland, Md.</b>   |  |                         |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>NOV 22 1982</b>                           |  | 25b. REGISTRAR'S SIGNATURE<br><b>John J. Connel</b>  |  |   |  |                             |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  |   |                   |   |  |                     |  |                                 |                  |  |  |  |
|--|--|--|--|---|-------------------|---|--|---------------------|--|---------------------------------|------------------|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |  |  |  |   | 2a. DATE OF DEATH |   |  |                     |  | 2b. HOUR                        |                  |  |  |  |
| FIRST MIDDLE LAST  |  |  |  |   | MONTH DAY YEAR    |   |  |                     |  | MONTH DAY HOURS MIN.            |                  |  |  |  |
| Hazel V Meese  |  |  |  |   | 11/ 18/ 82        |   |  |                     |  | 2:30a M                         |                  |  |  |  |
| 3. SEX   |  | 4. RACE  |  | 5. DATE OF BIRTH  |                   | 6. AGE (IN YEARS LAST BIRTHDAY)                                     |  |                     | 7. UNDER 1 YEAR  |                                 | 7. UNDER 24 HRS. |  |  |  |
| female   |  | white  |  | MONTH DAY YEAR  |                   | 81  |  |                     | MONTHS DAYS  |                                 | HOURS MIN.       |  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                   | 9. BALTIMORE CITY OR COUNTY OF DEATH                                |  |                     | 10. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) |                                 |                  | 10b. KIND OF BUSINESS OR INDUSTRY            |  |  |
| Maryland   |  | USA  |  |   |                   | Allegany  |  |                     | Housewife  |                                 |                  | Own Home                                     |  |  |
| 11. CITY OR TOWN OF DEATH  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  | 12a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |                   | 13d. INSIDE CITY LIMITS?  |  | 13e. STREET ADDRESS |  |                                 |                  |  |  |  |
| Frostburg, MD  |  | Frostburg Community Hospital   |  | Md STATE Allegany COUNTY Frostburg  |                   | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | Star Rt Box 5       |  |                                 |                  |  |  |  |
| 14. FATHER'S NAME  |  | 15. MOTHER'S MAIDEN NAME   |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)   |                   | 16b. SOCIAL SECURITY NO.  |  | 17. INFORMANT       |  | ADDRESS                         |                  |  |  |  |
| FIRST MIDDLE LAST  |  | FIRST MIDDLE LAST  |  |   |                   | 213 74 0139   |  | J Robison           |  | 48 Tarn Terrace, Frostburg, MD. |                  |  |  |  |
| James  |  | Ada Blocher  |  |   |                   |   |  |                     |  |                                 |                  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) 4360 Cardio Respiratory failure<br>DUE TO, OR AS A CONSEQUENCE OF (b) Central Vascular accident<br>DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |  |  |   |                   |   |  |                     |  |                                 |                  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE PRIMARY DISEASE OR CONDITION GIVEN IN PART I:<br>ASHD - Congestive heart failure, Myocardial infarction, Trichinosis   |  |  |  |   |                   |   |  |                     |  |                                 |                  |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?   |                   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?      |  |                     |  |                                 |                  |  |  |  |
|  |  |  |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |                   | YES <input type="checkbox"/> NO <input type="checkbox"/>            |  |                     |  |                                 |                  |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |                   |   |  |                     |  |                                 |                  |  |  |  |
|  |  |  |  |   |                   |   |  |                     |  |                                 |                  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                 |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |                   |   |  |                     |  |                                 |                  |  |  |  |
|  |  |  |  |   |                   |   |  |                     |  |                                 |                  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 6/5, 1975, to 11-18, 1982, that (I) (we) lost saw the deceased alive on 11-17, 1982, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |  |  |   |                   |   |  |                     |  |                                 |                  |  |  |  |
| 22b. SIGNATURE   |  | DEGREE   |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>                  |                   | 22c. DATE SIGNED  |  |                     |  |                                 |                  |  |  |  |
| Dr. S.L. Sandhir   |  |  |  |   |                   |   |  |                     |  |                                 |                  |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)  |  | 22e. ADDRESS   |  |   |                   |   |  |                     |  |                                 |                  |  |  |  |
| Dr. S.L. Sandhir   |  | 48 Tarn Terrace, Frostburg, MD   |  |   |                   |   |  |                     |  |                                 |                  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)  |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY  |                   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE                          |  |                     |  |                                 |                  |  |  |  |
| Burial   |  | Nov.20,1982  |  | Greenville Cemetery   |                   | Pocahontas, Penna   |  |                     |  |                                 |                  |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS   |  | 25a. DATE RECEIVED BY DEPT. OF HEALTH  |  | 25b. REGISTRAR'S SIGNATURE  |                   |   |  |                     |  |                                 |                  |  |  |  |
| Durst Funeral Home, Frostburg, Md. 21532   |  | NOV 24 1982  |  | John J. Smith   |                   |   |  |                     |  |                                 |                  |  |  |  |

BP

Dr. J. L. Sander

Nov. 20, 1982 Greenville Cemetery

Funeral

Nov. 20, 1982 Greenville Cemetery

Funeral Home, Greenville, S.C.

Adams

Adams

Blocher

Ida

Blodgett

212 N. 11th St. Robinson 48 Town Terrace, Frostburg, MD.

No

Frostburg, MD. Frostburg Community Hospital

Houseside

Own Home

Frostburg

X

Star Rt Box 5

Allegheny

MD

Allegheny

USA

X

Allegheny

West VI

MD

White

Female

Married

V

Married

Married

Married



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE  |  |  |  |  |  |   |                  |  |  |
|---|--|--|--|--|--|---|------------------|--|--|
| 1. FOR STATE REGISTRAR  |  |  |  |  | 8 2 2 7 6 9 3                          |   |                  |  |  |
| 1. DECEASED NAME (TYPE OR PRINT)  |  |  |  |  | 2a. DATE OF DEATH                      |   |                  |  |  |
| FIRST MIDDLE LAST   |  |  |  |  | MONTH DAY YEAR                         |   |                  |  |  |
| Helen J. Mellon   |  |  |  |  | 11 12 82                               |   |                  |  |  |
| 3. SEX  |  | 4. RACE  |  | 5. DATE OF BIRTH   |  | 6. AGE (IN YEARS LAST BIRTHDAY)                                     |                  | 7b. HOUR   |  |
| female  |  | white  |  | 1/29/08  |  | 74 YRS.   |                  | 2:30 PM  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH                                |                  |  |  |
| West Virginia   |  | USA  |  |  |  | Atlegany Co   |                  | MD.  |  |
| 10. CITY OR TOWN OF DEATH   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)       |                  | 12b. KIND OF BUSINESS OR INDUSTRY                              |  |
| Frostburg, MD.  |  | Frostburg Community Hospital   |  |  |  | Domestic  |                  | Residential  |  |
| 13a. STATE  |  | 13b. COUNTY  |  | 13c. CITY OR TOWN  |  | 13d. INSIDE CITY LIMITS?  |                  | 13e. STREET ADDRESS  |  |
| West Virginia   |  | Mineral  |  | Short Gap  |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                  | Rural  |  |
| 14. FATHER'S NAME   |  |  |  |  | 15. MOTHER'S MAIDEN NAME               |   |                  |  |  |
| FIRST MIDDLE LAST   |  |  |  |  | FIRST MIDDLE LAST                      |   |                  |  |  |
| Unknown   |  |  |  |  | Elizabeth Mellon                       |   |                  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)   |  | 16b. SOCIAL SECURITY NO.   |  | 17. INFORMANT ADDRESS  |  |   |                  |  |  |
| no  |  | 215 74 8558  |  | J Robison, 48 Tarn Terrace, Frbg, Md 21532   |  |   |                  |  |  |
| 18. CAUSE OF DEATH: Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Hepato Renal FAILURE</u><br><u>1749</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>LIVER AND LUNG METASTASIS</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(c) <u>CARCINOMA OF LEFT BREAST</u><br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u></u> |  |  |  |  |  |   |                  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |  |  | 20a. AUTOPSY?   |                  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |  |
| 10/5/81   |  |  |  |  |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                  | YES <input type="checkbox"/> NO <input type="checkbox"/>       |  |
| 21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |   |                  |  |  |
|   |  | HOUR A.M. MONTH DAY YEAR   |  |  |  |   |                  |  |  |
|   |  | P.M. 19  |  |  |  |   |                  |  |  |
| 21d. INJURY OCCURRED  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                    |  | 21f. LOCATION  |  |   |                  |  |  |
| WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  |  |  | STREET CITY OR TOWN COUNTY STATE   |  |   |                  |  |  |
| 22. I certify that (I) (this hospital) attended the deceased from <u>11/6</u> 19 <u>82</u> , to <u>10/12</u> 19 <u>82</u> , that (I) (we) lost saw the deceased alive on <u>11/12</u> 19 <u>82</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |  |  |  |  |   |                  |  |  |
| 27b. SIGNATURE  |  |  |  |  | DEGREE                                 |   | 27c. DATE SIGNED |  |  |
| <u>S. Chang M.D.</u>  |  |  |  |  |  |   |                  |  |  |
| 27d. PHYSICIAN'S NAME (TYPE OR PRINT)   |  |  |  |  | 27e. ADDRESS                           |   |                  |  |  |
| <u>S.T. Chang MD</u>  |  |  |  |  | <u>34 Broadway Frostburg, MD 21532</u> |   |                  |  |  |
| <u>SATURNINA T. CHANG M.D.</u>  |  |  |  |  | <u>34 BROADWAY FROSTBURG MD 21532</u>  |   |                  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)   |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY   |  | 23d. LOCATION   |                  |  |  |
| Burial  |  | 11/15/82   |  | Fort Ashby   |  | Fort Ashby Mineral W. Va.   |                  |  |  |
| 24. FUNERAL DIRECTOR  |  |  |  |  | 25a. DATE REC'D. BY REGISTRAR          |   |                  |  |  |
| NAME ADDRESS  |  |  |  |  | REGISTRAR'S SIGNATURE                  |   |                  |  |  |
| <u>John J. Hafer</u>  |  |  |  |  | <u>NOV 16 1982</u>                     |   |                  |  |  |
| <u>Hafer Chapel of the Hills</u>  |  |  |  |  | <u>LAVale, MD. 21502</u>               |   |                  |  |  |

BP

Water Chapel of the Hills, NVALE, NO. 21902  
 John J. Water  
 Fort Ashby

2.1. Chane NO 34 Broadway, Frostburg, MD 21532

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 215 74 8588 2 Robinson, 40 Tenn Terrace, Frio, MD 21532  
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1. Nelson

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 1 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE  |  |  |  | 8 2 2 7 6 9 4   |  |  |  |
|---|--|--|--|---|--|--|--|
| FOR<br>1. STATE REGISTRAR   |  |  |  | REG. NO.  |  |  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT) FIRST MIDDLE LAST<br>DORA ALMA MILLER   |  |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>NOVEMBER 30 1982   |  | 2b. HOUR<br>M  |  |
| 3. SEX<br>FEMALE  |  | 4. RACE<br>WHITE   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>JULY 9 1904   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>78<br>YRS. MONTHS DAYS HOURS MIN.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>MARYLAND   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>ALLEGANY COUNTY MD.  |  |
| 10. CITY OR TOWN OF DEATH<br>CUMBERLAND   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>SACRED HEART HOSPITAL |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>HOUSE WIFE  |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |
| 13a. STATE<br>MD.   |  |  |  | 13b. COUNTY<br>ALLEGANY   |  | 13c. CITY OR TOWN<br>LONACONING  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>GEORGE ANDREWS  |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>JANE SHAW  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>no  |  | 16b. SOCIAL SECURITY NO.<br>197 28 8569  |  | 17. INFORMANT<br>EDNA BEEMAN  |  | ADDRESS<br>LONACONING, MD.   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>cerebral hemorrhage</u><br>4029 DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>hypertensive cardiovascular disease</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(c)<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>18 hrs<br>20 years |  |  |  |   |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |  |  |   |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |  |  |   |  |  |  |
| 22b. SIGNATURE<br>DEGREE<br>DONALD MANGER, M.D.   |  |  |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>                  |  | 22c. DATE SIGNED<br>11 30 82   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>DONALD MANGER, M.D.  |  |  |  | 22e. ADDRESS<br>55 JACKSON STREET, LONACONING, MD 21539   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>BURIAL  |  | 23b. DATE<br>22/3/82   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>LAUREL HILL CEMETERY  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>MOSCOW MILLS ALLEGANY MD.  |  |
| 24. FUNERAL DIRECTOR<br>BOALS FUNERAL HOME: WESTERNPORT, MD 21560   |  |  |  | 25a. DATE REC'D. BY REGISTRAR<br>DEC 6 1982   |  | 25b. REGISTRAR'S SIGNATURE<br>John J. Carver   |  |

11/25/28 - 1928

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 2 7 6 9 5

1- FOR  
STATE  
REGISTRAR

REG. NO.

|   |  |   |   |   |  |  |   |  |
|---|--|---|---|---|--|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>THOMAS WILLIAM MOREHEAD</b>   |  |   | 2a. DATE OF DEATH<br>MONTH <b>11</b> DAY <b>26</b> YEAR <b>1982</b> |   | 2b. HOUR<br><b>1:55</b> AM   |  |   |  |
| 3. SEX<br><b>MALE</b>   |  | 4. RACE<br><b>WHITE</b>   |   | 5. DATE OF BIRTH<br>MONTH <b>11</b> DAY <b>1</b> YEAR <b>1926</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>56</b> YRS.  |   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>MARYLAND</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>ALLEGANY</b> MD.  |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>FROSTBURG</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>320 BRADDOCK APARTMENTS</b> |   |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>CHEMIST</b> |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>ABL</b> |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE AND ADMISSION)<br>13a. STATE <b>MARYLAND</b> 13b. COUNTY <b>ALLEGANY</b> 13c. CITY OR TOWN <b>FROSTBURG</b>   |  |   |   |   |  |  |   |  |
| 14. FATHER'S NAME<br><b>JOHN RAYMOND MOREHEAD</b>   |  |   |   | 15. MOTHER'S MAIDEN NAME<br><b>MARGARET SELL</b>  |  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>YES</b>  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>WW II</b>   |   | 17. INFORMANT<br>ADDRESS <b>FROSTBURG, MD. 21533</b><br><b>MRS. T. WILLIAM MOREHEAD, 320 BRADDOCK RD</b>  |  |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Metastatic Carcinoma</b><br><b>1739</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>DUE TO, OR AS A CONSEQUENCE OF:<br>(b) <b>Muco-Epididymoid Ca.</b><br>DUE TO, OR AS A CONSEQUENCE OF:<br>(c) _____ |  |   |   |   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH    |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)  |  |   |   |   |  |  |   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>11/14</b> , 19 <b>82</b> , to <b>11/22</b> , 19 <b>82</b> , that (I) (we) lost saw the deceased alive on <b>11/24</b> , 19 <b>82</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                               |  |   |   |   |  |  |   |  |
| 22b. SIGNATURE<br><b>Clarence J. Vincent, M.D.</b>  |  |   |   | DEGREE<br><b>MD</b>   |  | 22c. DATE SIGNED   |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Clarence J. Vincent, M.D.</b>   |  |   |   | 22e. ADDRESS<br><b>909-B SETON DRIVE, CUMBERLAND, MD.</b>   |  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br><b>BURIAL</b>  |  | 23b. DATE<br><b>11/29/82</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>ST. MICHAEL'S CEM.</b>   |  | 23d. LOCATION<br>CITY OR TOWN <b>FROSTBURG</b> COUNTY <b>ALLEGANY</b> STATE <b>MD.</b>                                     |   |  |
| 24. FUNERAL DIRECTOR<br>NAME <b>SOWERS FUNERAL HOME</b> ADDRESS <b>FROSTBURG</b>  |  |   |   | 25a. DATE REC'D. BY REGISTRAR<br><b>DEC 1 1982</b>  |  | 25b. REGISTRAR'S SIGNATURE<br><b>John J. Conner</b>  |   |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in accordance with the law, it should be detached for use as the burial-transit permit. Then please return the carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.





TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR 24 HOURS. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1- FOR  
STATE  
REGISTRAR

|  |                       |   |   |   |   |
|--|-----------------------|---|---|---|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>VICTOR Odell MORELAND</b>   |                       | 2a. DATE OF DEATH<br>KNOWN OF DEATH <input checked="" type="checkbox"/> ESTI-MATED <input type="checkbox"/> <b>11/28/82</b>   |   | 2b. HOUR <b>1140A</b>   |   |
| 3. SEX<br><b>M</b>   | 4. RACE<br><b>Cau</b> | 5. DATE OF BIRTH<br>MONTH <b>12</b> DAY <b>06</b> YEAR <b>64</b>  | 6. AGE (IN YEARS)<br>LAST BIRTHDAY <b>17</b> YRS.                                       | IF UNDER 1 YR.<br>MONTHS <b></b> DAYS <b></b>   | IF UNDER 24 HRS.<br>HOURS <b></b> MIN. <b></b>                                      |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Va.</b>  |                       | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   |
| 7c. DATE PRONOUNCED DEAD<br><b>11/28/82</b>  |                       | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Allegany</b>   |   | MD.   |   |
| 10. CITY OR TOWN OF DEATH<br><b>Cumberland</b>   |                       | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Memorial Hospital</b>  |   | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Student</b>   |   |
| 12b. KIND OF BUSINESS OR INDUSTRY  |                       | 13a. USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE <b>W. Va</b> 13b. COUNTY <b>Mineral</b> 13c. CITY OR TOWN <b>Keyser</b> |   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> 13e. STREET ADDRESS <b>111 Mozelle Street</b>               |   |
| 4. FATHER'S NAME<br>FIRST <b>Victor</b> MIDDLE <b>Odell</b> LAST <b>Moreland Sr</b>  |                       |   | 15. MOTHER'S MAIDEN NAME<br>FIRST <b>June</b> MIDDLE <b>Pauline</b> LAST <b>Parrish</b> |   |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN) <b>NO</b>  |                       | 16b. SOCIAL SECURITY NO.<br><b>234 98 2699</b>  |   | 17. INFORMANT ADDRESS<br><b>Pauline Moreland Keyser, W.Va</b>   |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1 DEATH WAS CAUSED BY:<br><b>9554</b> IMMEDIATE CAUSE (a) <b>Self-inflicted gun shot wound to the head</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____  |                       |   |   |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>2 days</b>                       |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1   |                       |   |   |   |   |
| 19a. DATE OF OPERATION   |                       | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?   |   |   | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |                       | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>930 P hrs 11/26/82</b>  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)<br><b>Self-inflicted gun shot wound to head</b>                               |   |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>  |                       | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)<br><b>Home</b>  |   | 21f. LOCATION<br>STREET <b>111 Mozelle</b> CITY OR TOWN <b>Keyser</b> COUNTY <b>Mineral</b> STATE <b>W. Va</b>  |   |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and in my opinion death resulted from Natural causes <input type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input checked="" type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/> . |                       |   |   |   |   |
| ACTUAL SIGNATURE<br><i>Paul Snow</i>   |                       | TITLE (SPECIFY)<br>M.D. <b>Asist. Dpty</b>  |   | DATE SIGNED <b>11/28/82</b>   |   |
| EXAMINER'S NAME (TYPE OR PRINT)<br><b>Paul Snow, M.D.</b>  |                       | ADDRESS <b>Memorial Hospital</b>  |   |   |   |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>   |                       | 23b. DATE<br><b>11-30-82</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Kalbaugh Cemetery</b>  |   |
| 23d. LOCATION<br>CITY OR TOWN <b>Elk Garden</b> COUNTY <b>Mineral</b> STATE <b>W.Va</b>  |                       | 25a. DATE REC'D. BY REGISTRAR <b>DEC 6 1982</b> REGISTRAR'S SIGNATURE <i>John J. Canale</i>   |   |   |   |
| 24. FUNERAL DIRECTOR<br>NAME <b>David A. Burdock</b> ADDRESS <b>Kitzmiller, Md</b>   |                       |   |   |   |   |



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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 2 7 6 9 7

FOR  
1- STATE  
REGISTRAR

REG. NO.

|  |   |   |   |  |   |
|--|---|---|---|--|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>HARRY C NIELD</b>  |   |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>NOVEMBER 28, 1982</b>                                 |  | 2b. HOUR<br><b>13:05</b><br>P M                                 |
| 3. SEX<br><b>Male</b>  | 4. RACE<br><b>White</b>   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>March 18, 1908</b>   |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>74</b><br>YRS.                                 | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>   | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Allegany</b> MD.                          |   |
| 10. CITY OR TOWN OF DEATH<br><b>CUMBERLAND</b>   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>MEMORIAL HOSPITAL</b> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Retired</b>              |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Steel Co.</b>           |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><b>Maryland</b>  |   |   | 13b. COUNTY<br><b>Allegany</b>  |  |   |
| 13c. CITY OR TOWN<br><b>Cumberland</b>   |   |   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |   |
| 13e. STREET ADDRESS<br><b>127 Humbird St.</b>  |   |   |   |  |   |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>George Wm. Nield</b>  |   |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Bessie A. Fauble</b>                        |  |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>Yes</b>   |   | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>War II 214-05-9153</b>  |   | 17. INFORMANT<br>ADDRESS<br><b>Mrs. Linda Nield, Cumberland, Wife</b>                |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br><b>4413 Ruptured Abdominal Aortic Aneurysm</b><br>IMMEDIATE CAUSE (a)<br>DUE TO, OR AS A CONSEQUENCE OF (b)<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>DUE TO, OR AS A CONSEQUENCE OF (c)<br><b>2 weeks</b> |   |   |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>2 weeks</b>  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:<br><b>Renal failure, pneumonia, ischemic colitis</b>  |   |   |   |  |   |
| 19a. DATE OF OPERATION<br><b>11/14/82 + 11/16/82</b>   |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>Ruptured abdominal aortic aneurysm<br/>Related renal artery occlusion</b>                            |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |   |  |   |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |   | 21d. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)               |   |
| 21e. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |   |  |   |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>11/14, 1982</b> to <b>11/28, 1982</b> , that (I) (we) last saw the deceased alive on <b>11/28, 1982</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |   |   |   |  |   |
| 22b. SIGNATURE<br><b>Philip J. Schroeder, M.D.</b>   |   | DEGREE<br>ATTENDING <input checked="" type="checkbox"/> MEDICAL <input type="checkbox"/> STAFF <input type="checkbox"/><br>PHYSICIAN DIRECTOR PHYSICIAN     |   | 22c. DATE SIGNED<br><b>11/28/82</b>  |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>DR. PHILIP SCHROEDER</b>   |   | 22e. ADDRESS<br><b>MEMORIAL HOSPITAL MEDICAL BLDG.<br/>CUMBERLAND, MD. 21502</b>  |   |  |   |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>  |   | 23b. DATE<br><b>Dec. 1, 1982</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Sunset Memorial Park</b>                    |   |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Cumberland, Allegany, Md.</b>   |   | 24. FUNERAL DIRECTOR<br>NAME<br><b>James F. Scarpelli Cumberland, Md.</b>   |   |  |   |
| 25a. DATE REC'D. BY REGISTRAR<br><b>DEC 7 1982</b>   |   | 25b. REGISTRAR'S SIGNATURE<br><b>John J. Carver</b>   |   |  |   |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 10 days after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should remain with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |   |  | 8 2 2 7 6 9 8   |  |  |  |
|---|--|---|--|---|--|--|--|
| 1. FOR STATE REGISTRAR  |  |   |  | REG. NO.  |  |  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>GEORGE ALOYSIOUS NOLAN</b>   |  |   |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>NOVEMBER 19, 1982</b>   |  | 2b. HOUR<br><b>9:45 AM</b>   |  |
| 3. SEX<br><b>MALE</b>   |  | 4. RACE<br><b>WHITE</b>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>12/24/16</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>65</b> YRS.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>PENNSYLVANIA</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>ALLEGANY COUNTY</b> MD.   |  |
| 10. CITY OR TOWN OF DEATH<br><b>CUMBERLAND</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>SACRED HEART HOSPITAL</b> |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>LABORER</b>  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>CELANESE</b>   |  |
| 13a. STATE<br><b>MARYLAND</b>   |  |   |  | 13b. COUNTY<br><b>ALLEGANY</b>  |  | 13c. CITY OR TOWN<br><b>KLONDIKE</b>   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>DANIEL NOLAN</b>   |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>MARY CANNON</b>   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) <b>YES</b>   |  |   |  | 16b. SOCIAL SECURITY NO.<br><b>214-16-2944</b>  |  | 17. INFORMANT<br>ADDRESS <b>FROSTBURG, MD.</b><br><b>MRS. GEORGE NOLAN, RT 1, BOX 284,</b>                                 |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardiac arrest</b><br><b>1629</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Metastatic Ca of the Lung</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) <b>Advanced Ca of the Prostate</b> |  |   |  |   |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)  |  |   |  |   |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>Nov 19, 19 82</b> , to <b>Nov 19, 19 82</b> . That (I) (we) lost saw the deceased alive on <b>Nov 19, 19 82</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                                  |  |   |  |   |  |  |  |
| 21g. SIGNATURE<br><b>Chang Oh, M.D.</b>   |  |   |  | DEGREE<br><b>M.D.</b>   |  | 22c. DATE SIGNED   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>CHANG OH, M.D.</b>  |  |   |  | 22e. ADDRESS<br><b>48 TARN TERRACE, FROSTBURG, MD 21532</b>   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>BURIAL</b>   |  | 23b. DATE<br><b>11/22/82</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>ST. JOSEPH'S CEM.</b>  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>MIDLAND ALLEGANY MD</b>   |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>60 WEST MAIN STREET<br/>SOWERS FUNERAL HOME; FROSTBURG, MD 21532</b>   |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>NOV 26 1982</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>   |  |

BP



|              |          |             |                                   |               |         |
|--------------|----------|-------------|-----------------------------------|---------------|---------|
| YES          | WM II    | 214-10-5044 | MRS. GEORGE NOLAN, RT 1, BOX 384, | HOUSTON, MD.  | CANNON  |
| DANIEL       | NOLAN    | JOSEPH      |                                   |               |         |
| MARYLAND     | ALLEGANY | WINDING     | X                                 | RT 1, BOX 384 | CHINESE |
| CUMBERLAND   |          | 21513       |                                   |               |         |
| PENNSYLVANIA | U.S.A.   |             |                                   |               |         |
| WHITE        | 12-10-10 |             |                                   |               |         |
| MALE         |          |             |                                   |               |         |

SOME'S FUNERAL HOME: HOUSTON, MD 21513  
ST. JOSEPH'S CH. MIDLAND ALLEGANY MD.  
BUTAL 11-22-82  
GRACE CH. MD.  
NO TAE TERRACE, HOUSTON, MD 21513



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 2 7 6 9 9

1. FOR  
STATE  
REGISTRAR

REG. NO.

|   |  |   |   |   |   |   |  |
|---|--|---|---|---|---|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>Phoebe P. Nutt   |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>11 28 82 |   |   | 2b. HOUR<br>10:50am   |  |
| 3. SEX<br>Female  |  | 4. RACE<br>White  |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>02 29 96  |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br>86 YRS.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>W. Va.   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Allegany County MD.                                     |  |
| 10. CITY OR TOWN OF DEATH<br>Frostburg  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Frostburg Community Hospital |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Nurse Aid   |   | 12b. KIND OF BUSINESS OR INDUSTRY<br>Nursing  |  |
| 13a. STATE<br>Maryland  |  | 13b. COUNTY<br>Allegany   |   | 13c. CITY OR TOWN<br>Frostburg  |   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 13e. STREET ADDRESS<br>13 Park Avenue   |  | 13f. HOME   |   |   |   |   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>James Rexroad   |  |   |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Olive Hardman  |   |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>NO  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>233-44-6937  |   | 17. INFORMANT<br>ADDRESS<br>K. Carter, Frostburg, Comm. Hospital  |   |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>4292 IMMEDIATE CAUSE (a) ACVD<br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____ |  |   |   |   |   |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>25 YRS.  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a<br>NONE  |  |   |   |   |   |   |  |
| 19a. DATE OF OPERATION<br>N/A   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)<br>N/A   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)<br>✓   |   |   |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)<br>✓   |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE<br>✓  |   |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 11-22, 1982, to 11-28, 1982, that (I) (we) lost saw the deceased alive on 11-28, 1982, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death.                          |  |   |   |   |   |   |  |
| 22b. SIGNATURE<br>Martin Rothstein M.D.   |  |   |   | DEGREE<br>M.D.  |   | 22c. DATE SIGNED<br>11/28/82  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Martin Rothstein, M.D.   |  |   |   | 22e. ADDRESS<br>48 Tarn Terrace, Frostburg, MD 21532  |   |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial   |  | 23b. DATE<br>12/1/82  |   | 23c. NAME OF CEMETERY OR CREMATORY<br>I.O.O.F. Cemetery   |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Harrisville Ritchie W.V.                          |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Charles R. Bonar Harrisville, W.Va.   |  |   |   | 25a. DATE REC'D. BY REGISTRAR<br>DEC 2 1982   |   | 25b. REGISTRAR'S SIGNATURE<br>John J. Carver  |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

0.9. 1994-1995

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  |   |  |  |  |  |  | 8 2 2 7 7 0 0                                |
|--|--|--|--|---|--|--|--|--|--|--|
| 1. FOR STATE REGISTRAR   |  |  |  |   |  |  |  |  |  | REG. NO.                                     |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST<br><b>BERNARD DAVID PRICE</b>   |  |  |  |   |  | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>11 13 82</b>  |  | 2b. HOUR<br><b>1857HRS</b>   |  |  |
| 3. SEX<br><b>MALE</b>  |  | 4. RACE<br><b>WHITE</b>  |  | 5. DATE OF BIRTH MONTH DAY YEAR<br><b>05 06 1928</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>56</b>   |  | 7. IF UNDER 1 YEAR IF UNDER 24 HRS<br>MONTHS DAYS HOURS MIN.   |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U S A</b>   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Allegany</b>  |  |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>CUMBERLAND MD</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>MEMORIAL HOSPITAL CUMB MD</b> |  |   |  | 12a. USUAL OCCUPATION<br><b>High School Teacher</b>  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Education</b>  |  |  |
| 13a. STATE<br><b>MARYLAND</b>  |  |  |  |   |  | 13b. COUNTY<br><b>ALLEGANY</b>   |  | 13c. CITY OR TOWN<br><b>CUMBERLAND</b>   |  |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br><b>Walter C. Price</b>  |  |  |  |   |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><b>Myrtle Stickley</b>   |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br><b>Yes, W. W. # 2</b>   |  |  |  |   |  | 16b. SOCIAL SECURITY NO.<br><b>217 28 0686</b>   |  | 17. INFORMANT ADDRESS<br><b>Mrs. Gwendolyn Price, 1801 Holland St. Cumb.</b>   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardiac Arrest</b><br>4149<br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>Cerebral Artery Disease</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>DUE TO, OR AS A CONSEQUENCE OF (c)<br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><b>Rheumatic Valvular disease</b> |  |  |  |   |  |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>11-13-82</b> to <b>11-13-82</b> , that (I) (we) lost<br>saw the deceased alive on <b>11-13-82</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death.  |  |  |  |   |  |  |  |  |  |  |
| 22b. SIGNATURE<br><b>Robustiano J. Barbera</b>   |  |  |  |   |  | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED<br><b>11-15-82</b>  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>ROBUSTIANO BARBERA</b>   |  |  |  |   |  | 22e. ADDRESS<br><b>Memorial Hosp. Med. Bldg. Cumberland, Md.</b>   |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>   |  | 23b. DATE<br><b>11/17/82</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Rose Hill Cemetery</b>   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Cumberland, Allegany Maryland</b>   |  |  |  |  |
| 24. FUNERAL DIRECTOR<br><b>H. Wayne George</b>   |  |  |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>NOV 19 1982</b>  |  | 25b. REGISTRAR'S SIGNATURE<br><b>John J. Lohr</b>  |  |  |

11 15 02 1877

WEDNESDAY DAVID PRICE

WHITE

1914

CHURCHMAN RD. HENRIKSON HOSPITAL CURE RD. INDIANAPOLIS, IND.

ALLEGANY CO. PENN. 1901 MILLMAN STREET

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

BP

1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 2 7 7 0 1

REG. NO.

|   |  |  |  |   |   |  |   |  |  |
|---|--|--|--|---|---|--|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>Jessie B. Rankin</b>   |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>11 28 82</b>                             |   |   | 2b. HOUR<br><b>9:30 PM</b>   |   |  |  |
| 3. SEX<br><b>Female</b>   |  | 4. RACE<br><b>White</b>  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>10 16 91</b>   |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>91</b>   |   | 7. IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.<br><b>YRS.</b>  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>MARYLAND</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>United States</b>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Allegheny County</b> MD.                  |   |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Frostburg</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Frostburg Community Hospital</b> |  |   |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>HOUSEWIFE</b> |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>OWN HOME</b>   |  |
| 13a. STATE<br><b>MD</b>   |  |  | 13b. COUNTY<br><b>Allegheny</b>  |   | 13c. CITY OR TOWN<br><b>Frostburg</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>JOHN McFARLAND</b>   |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>ELIZABETH LOAR</b>             |   |   |  |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>NO</b>   |  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>N.A.</b>             |   | 17. INFORMANT<br><b>D. Nolan</b>  |  | ADDRESS<br><b>48 Tarn Terrace Frostburg, MD 21532</b>   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br><b>4860 IMMEDIATE CAUSE (a) PNEUMONIA - RT. LUNG. - LOWER LOBE</b>   |  |  |  |   |   |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>6 WEEKS ???</b>   |  |
| DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____   |  |  |  |   |   |  |   |  |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(c) _____   |  |  |  |   |   |  |   |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____  |  |  |  |   |   |  |   |  |  |
| 19a. DATE OF OPERATION<br><b>N/A</b>  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>✓</b>                       |   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)<br><b>N/A</b>  |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>✓</b><br>P.M. <b>19</b>      |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)<br><b>✓</b> |  |   |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>  |  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)<br><b>✓</b> |   | 21f. LOCATION<br>STREET <b>✓</b> CITY OR TOWN COUNTY STATE                                |  |   |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>10-27</b> , 19 <b>82</b> , to <b>11-28</b> , 19 <b>82</b> , that (I) (we) last saw the deceased alive on <b>11-28</b> , 19 <b>82</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |   |   |  |   |  |  |
| 22b. SIGNATURE<br><b>Martin M. Rothstein, M.D.</b>  |  |  |  |   |   | DEGREE<br><b>M.D.</b>  |   | 22c. DATE SIGNED<br><b>11/29/82</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Martin M. Rothstein, M.D.</b>   |  |  |  |   |   | 22e. ADDRESS<br><b>48 Tarn Terrace Frostburg, MD 21532</b>                           |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>BURIAL</b>   |  | 23b. DATE<br><b>12/1/82</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>FROSTBURG MEM. PK</b>  |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>FROSTBURG ALLEGANY MD</b>           |   |  |  |
| 24. FUNERAL DIRECTOR<br>NAME <b>William M. Sowers</b> ADDRESS <b>60 W. MAIN ST.</b>   |  |  |  | DATE REC'D. BY REGISTRAR<br><b>DEC 6 1982</b>   |   | REGISTRAR'S SIGNATURE<br><b>John J. Givens</b>                                       |   |  |  |
| SOWERS FUNERAL HOME FROSTBURG   |  |  |  |   |   |  |   |  |  |

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  | 8 2 2 7 1 0 2   |  |  |   |
|--|--|--|--|---|--|--|---|
| 1. FOR STATE REGISTRAR   |  |  |  | REG. NO.  |  |  |   |
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>ELEANOR ANNA RAY   |  |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>NOVEMBER 17, 1982  |  | 2b. HOUR<br>12:00 P.M.   |   |
| 3. SEX<br>FEMALE   |  | 4. RACE<br>WHITE   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>OCTOBER 21 1921   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>61 YRS.   |   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>MARYLAND  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>ALLEGANY COUNTY MD.  |   |
| 10. CITY OR TOWN OF DEATH<br>CUMBERLAND  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>SACRED HEART HOSPITAL |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>REGISTERED NURSE  |  | 12b. KIND OF BUSINESS OR INDUSTRY  |   |
| 13a. STATE<br>MARYLAND   |  |  |  | 13b. COUNTY<br>ALLEGANY   |  | 13c. CITY OR TOWN<br>CUMBERLAND  |   |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>FREDERICK J. KLIFFNER  |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>ANNA TRAUTERMAN  |  |  |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>YES  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>WWII 220-46-4866  |  | 17. INFORMANT<br>ADDRESS<br>SEVERNA PARK, MD.<br>RYDER C. RAY SR. 206 BENFIELD ROAD 21146   |  |  |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>HEPATIC COMA</u><br><u>5712</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <u>Uremia</u><br>(c) <u>Alcoholism</u>  |  |  |  |   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><u>1 WK</u><br><u>YRS</u><br><u>YRS</u> |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |  |  |   |  |  |   |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |   |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |   |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>NOV 17</u> , 19 <u>82</u> , to <u>NOV 17</u> , 19 <u>82</u> , that (I) (we) last saw the deceased alive on <u>NOV 17</u> , 19 <u>82</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |   |  |  |   |
| 22b. SIGNATURE<br><u>[Signature]</u>   |  |  |  | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>        |  | 22c. DATE SIGNED<br><u>11/19/82</u>  |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><u>BRUCE D. BEHOUNEK, M.D.</u>  |  |  |  | 22e. ADDRESS<br>BMG 912 SETON DRIVE, CUMBERLAND, MD 21502   |  |  |   |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>BURIAL  |  | 23b. DATE<br>NOV 20 1982   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>TRINITY LUTH. CEMETERY CUMBERLAND ALLEGANY MARYLAND   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE   |   |
| 24. FUNERAL DIRECTOR<br>SILCOX MERRITT FUNERAL HOME  |  |  |  | 404 DECATUR STREET<br>CUMBERLAND, MD. 21502   |  | 25a. DATE REC'D BY REGISTRAR<br>NOV 22 1982  |   |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 2 7 7 0 3

REG. NO.

|   |         |                  |  |  |  |   |  |  |
|---|---------|------------------|--|--|--|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)   |         |                  | 2a. DATE OF DEATH  |  |  | 2b. HOUR  |  |  |
| THOMAS JOHN RICHARDS  |         |                  | NOVEMBER 18, 1982  |  |  | 03:50 AM  |  |  |
| 3. SEX  | 4. RACE | 5. DATE OF BIRTH | 6. AGE (IN YEARS LAST BIRTHDAY)  |  |  | IF UNDER 1 YEAR   |  | IF UNDER 24 HRS.   |
| Male  | White   | June 5, 1908     | 74   |  |  | MONTHS  |  | DAYS   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   |         |                  | 7b. CITIZEN OF WHAT COUNTRY?   |  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  |
| Maryland  |         |                  | U.S.A.   |  |  | 9. BALTIMORE CITY OR COUNTY OF DEATH  |  |  |
| 10. CITY OR TOWN OF DEATH   |         |                  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION                |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)   |  |  |
| Cumberland  |         |                  | SACRED HEART HOSPITAL  |  |  | Street Dept. City   |  |  |
| 13a. STATE  |         |                  | 13b. CITY OR TOWN  |  |  | 13c. STREET ADDRESS   |  |  |
| Maryland  |         |                  | Allegany   |  |  | 187 S. Water St.  |  |  |
| 14. FATHER'S NAME   |         |                  | 15. MOTHER'S MAIDEN NAME   |  |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?  |  |  |
| James D. Richards   |         |                  | Margaret Wellings  |  |  | No  |  |  |
| 16b. SOCIAL SECURITY NO.  |         |                  | 17. INFORMANT  |  |  | ADDRESS   |  |  |
| 213-09-6494   |         |                  | Mrs. Mandella Richards, Frostburg, Md.                                 |  |  |   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)   |         |                  |  |  |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                   |
| PART I. DEATH WAS CAUSED BY:  |         |                  |  |  |  |   |  |  |
| IMMEDIATE CAUSE (a) Overwhelming Sepsis   |         |                  |  |  |  |   |  | 5 days   |
| DUE TO, OR AS A CONSEQUENCE OF  |         |                  |  |  |  |   |  |  |
| (b) Cholangitis   |         |                  |  |  |  |   |  |  |
| DUE TO, OR AS A CONSEQUENCE OF  |         |                  |  |  |  |   |  |  |
| (c) Complete Bile duct obstruction. Ca. Pancreas  |         |                  |  |  |  |   |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I:  |         |                  |  |  |  |   |  |  |
| COPD. Duodenal ulcer. Cirrhosis (alcoholic)   |         |                  |  |  |  |   |  |  |
| 19a. DATE OF OPERATION  |         |                  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |  |  | 20a. AUTOPSY?   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |
|   |         |                  |  |  |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | YES <input type="checkbox"/> NO <input type="checkbox"/>       |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |         |                  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)  |  |  |
|   |         |                  |  |  |  |   |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK<br>NOT WHILE <input type="checkbox"/> AT WORK  |         |                  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |
|   |         |                  |  |  |  |   |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 10/5/82 to 11/18/82, that (I) (we) lost saw the deceased alive on 11/17/82, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death. |         |                  |  |  |  |   |  |  |
| 22b. SIGNATURE  |         |                  | DEGREE   |  |  | 22c. DATE SIGNED  |  |  |
| SL Sandhir  |         |                  | M.D.   |  |  | 11/18/82  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)   |         |                  | 22e. ADDRESS   |  |  |   |  |  |
| SIKANDER SANDHIR, M.D.  |         |                  | 48 TARN TERRACE FROSTBURG, MD 21532                                    |  |  |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)   |         |                  | 23b. DATE  |  |  | 23c. NAME OF CEMETERY OR CREMATORY  |  |  |
| Burial  |         |                  | Nov. 20, 82  |  |  | Frostburg Mem. Park Frostburg, Maryland   |  |  |
| 24. FUNERAL DIRECTOR NAME   |         |                  | 25a. DATE REC'D. BY REGISTRAR  |  |  | 25b. REGISTRAR'S SIGNATURE  |  |  |
| DURST FUNERAL HOME  |         |                  | NOV 24 1982  |  |  | John J. Carney  |  |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 48 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH - 16 50M 7/77  
(VR A 15 (4))

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |   |  |   |  |  |  |  |  |
|--|--|---|--|---|--|--|--|--|--|
| 1. FOR STATE REGISTRAR   |  | 2a. DATE OF DEATH   |  |   |  | 2b. EQU. A M   |  |  |  |
| 1. DECEASED NAME (TYPE OR PRINT)   |  | 2a. DATE OF DEATH   |  |   |  | 2b. EQU. A M   |  |  |  |
| FIRST MIDDLE LAST  |  | MONTH DAY YEAR  |  |   |  | MONTHS DAYS HOURS MIN.   |  |  |  |
| Joan Etta Roach  |  | November 22, 1982   |  |   |  | 6:45 A M   |  |  |  |
| 3. SEX   |  | 4. RACE   |  | 5. DATE OF BIRTH  |  | 6. AGE (IN YEARS LAST BIRTHDAY)  |  | 7. IF UNDER 1 YEAR   |  |
| Female   |  | White   |  | Nov. 3, 1921  |  | 61 YRS.  |  | MONTHS DAYS HOURS MIN.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |  | 7b. CITIZEN OF WHAT COUNTRY?  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH   |  |  |  |
| Maryland   |  | USA   |  |   |  | Allegany MD.   |  |  |  |
| 10. CITY OR TOWN OF DEATH  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)               |  | 12b. KIND OF BUSINESS OR INDUSTRY                              |  |
| Mt. Savage   |  | Box 517 Main St.  |  |   |  | Beautician Form. Beauty  |  | Shop   |  |
| 13. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |  |   |  |   |  |  |  |  |  |
| 13a. STATE   |  | 13b. COUNTY   |  | 13c. CITY OR TOWN   |  | 13d. INSIDE CITY LIMITS?   |  | 13e. STREET ADDRESS  |  |
| MD   |  | Allegany  |  | Mt. Savage  |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>            |  | Box 517 Main St. 21545   |  |
| 14. FATHER'S NAME  |  |   |  |   | 15. MOTHER'S MAIDEN NAME                 |  |  |  |  |
| FIRST MIDDLE LAST  |  |   |  |   | FIRST MIDDLE LAST                        |  |  |  |  |
| Jacob Carl Cessna  |  |   |  |   | Ellen C. Miller                          |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)   |  |   |  |   | 16b. SOCIAL SECURITY NO.                 |  | 17. INFORMANT ADDRESS                      |  |  |
| No   |  |   |  |   | 219-14-6903                              |  | William J. Roach Mt. Savage 21545          |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Renal cell Carcinoma, Rt Kidney</u><br><u>1890</u><br>DUE TO, OR AS A CONSEQUENCE OF <u>of Brain &amp; Bone</u><br>(b) <u>Metastasis</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>10 mos.</u>         |  |   |  |   |  |  |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)   |  |   |  |   |  |  |  |  |  |
| 19a. DATE OF OPERATION   |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |   |  | 20a. AUTOPSY?  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |  |
|  |  |   |  |   |  | YES <input type="checkbox"/> NO <input type="checkbox"/>                       |  | YES <input type="checkbox"/> NO <input type="checkbox"/>       |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |  |  |  |
| 22a. I certify that (I (this hospital) attended the deceased from <u>3/7</u> 19 <u>82</u> , to <u>11/22</u> 19 <u>82</u> , that (I) (we) last saw the deceased alive on <u>19</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |   | 22b. SIGNATURE<br><u>Angel H. Roque</u> M.D.<br>DEGREE                 |   |  | 22c. DATE SIGNED<br><u>11/22/82</u>  |  | 22d. PHYSICIAN'S NAME (TYPE OR PRINT)                          |  |
|  |  |   | 22e. ADDRESS<br><u>48 Broadway St., Frostburg, MD</u>                  |   |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)  |  |   | 23b. DATE  |   | 23c. NAME OF CEMETERY OR CREMATORY       |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE |  |  |
| Burial   |  |   | Nov. 24, 1982  |   | St. Patrick's Cem Mt. Savage Allegany MD |  |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME   |  |   | 25a. DATE REC'D. BY REGISTRAR  |   |  | 25b. REGISTRAR'S SIGNATURE   |  |  |  |
| William G. Kight Cumberland, MD 21502  |  |   | NOV 26 1982  |   |  | <u>John J. Conner</u>  |  |  |  |

MEDICAL CERTIFICATION

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. GIVE PAGE 4 TO THE MEDICAL EXAMINER. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201. PRIOR TO BURIAL, CREMATION, OR REMOVAL.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH   |  |                             |  |  |  |   |  |  |  | REG. NO. 2 2 7 7 0 5   |  |
|---|--|-----------------------------|--|--|--|---|--|--|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) <b>Bradley A Robertson</b>   |  |                             |  |  |  | 2b. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> MONTH <b>11</b> DAY <b>4</b> YEAR <b>1982</b> |  | 2c. DATE OF DEATH <input type="checkbox"/> MONTH <b>11</b> DAY <b>4</b> YEAR <b>1982</b>   |  | 2d. HOUR <b>11:30 AM</b>   |  |
| 3. SEX <b>M</b>   |  | 4. RACE <b>W</b>            |  | 5. DATE OF BIRTH MONTH <b>9</b> DAY <b>1</b> YEAR <b>1968</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY) <b>14</b> YRS.  |  | IF UNDER 1 YR. MONTHS <b>14</b> DAYS <b>14</b> HOURS <b>14</b> MIN.  |  | 7c. DATE PRONOUNCED DEAD MONTH <b>11</b> DAY <b>4</b> YEAR <b>1982</b> |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>   |  |                             |  | 7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>  |  |   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH <b>Allegany</b> MD.               |  |
| 10. CITY OR TOWN OF DEATH <b>Cumberland</b>   |  |                             |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Memorial Hospital</b> |  |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Student</b>   |  | 12b. KIND OF BUSINESS OR INDUSTRY <b>High School</b>                   |  |
| USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |  |                             |  |  |  | 13a. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>                         |  | 13b. STREET ADDRESS <b>Box 360</b>   |  |  |  |
| 13a. STATE <b>Maryland</b>  |  | 13b. COUNTY <b>Allegany</b> |  | 13c. CITY OR TOWN <b>Oldtown</b>   |  | 14. FATHER'S NAME FIRST <b>LEROY</b> MIDDLE <b>Robertson</b> LAST <b>Robertson</b>                        |  | 15. MOTHER'S MAIDEN NAME FIRST <b>Janice</b> MIDDLE <b>Neal</b> LAST <b>Neal</b>   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>no</b>  |  |                             |  | 16b. SOCIAL SECURITY NO. <b>8199</b>   |  | 17. INFORMANT <b>Mr. LeRoy Robertson, Oldtown, Md. Father</b>   |  | ADDRESS <b>Oldtown, Md.</b>  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1 DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Intracranial Hemorrhage</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last:<br>(b) <b>Head trauma secondary to</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>motorcycle accident</b>  |  |                             |  |  |  |   |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                           |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):   |  |                             |  |  |  |   |  |  |  |  |  |
| 19a. DATE OF OPERATION <b>11-2-82</b>   |  |                             |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? <b>Ruptured spleen</b>   |  |   |  | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |  |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |  |                             |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>19</b>   |  |   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) <b>Riding a motorcycle</b>   |  |  |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>   |  |                             |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) <b>dropping on street oldtown</b>                                    |  |   |  | 21f. LOCATION STREET <b>Oldtown</b> CITY OR TOWN <b>Oldtown</b> COUNTY <b>Allegany</b> STATE <b>Md.</b>  |  |  |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> . |  |                             |  |  |  |   |  |  |  |  |  |
| ACTUAL SIGNATURE <b>Francisco Reyes</b>   |  |                             |  | TITLE (SPECIFY) <b>Deputy</b> M.D.   |  |   |  | MEDICAL EXAMINER <b>Francisco Reyes</b> DATE SIGNED <b>11-4-82</b>   |  |  |  |
| EXAMINER'S NAME (TYPE OR PRINT) <b>Francisco Reyes</b>  |  |                             |  | ADDRESS <b>900 Seton Dr. Cumberland</b>  |  |   |  | 25b. DATE REC'D. BY REGISTRAR <b>NOV 8 1982</b>  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>   |  |                             |  | 23b. DATE <b>11-7-1982</b>   |  |   |  | 23c. NAME OF CEMETERY OR CREMATORY <b>Green Ridge Cemetery</b>   |  |  |  |
| 23d. LOCATION CITY OR TOWN <b>Near Oldtown</b> COUNTY <b>Allegany</b> STATE <b>Md.</b>  |  |                             |  | 25a. REGISTRAR'S SIGNATURE <b>John J. Conner</b>   |  |   |  |  |  |  |  |
| 24. FUNERAL DIRECTOR NAME <b>James F. Scarpelli</b> ADDRESS <b>Cumberland, Md.</b>  |  |                             |  | 25c. REGISTRAR'S SIGNATURE <b>John J. Conner</b>   |  |   |  |  |  |  |  |

1-1-1950  
Dear Sir,  
I have the honor to acknowledge the receipt of your letter of the 28th inst. in relation to the above mentioned matter.  
The same has been forwarded to the proper authorities for their consideration.  
Very respectfully,  
[Signature]  
[Title]

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 2 7 7 0 6

FOR  
1- STATE  
REGISTRAR

REG. NO.

|  |  |  |  |   |   |  |   |  |
|--|--|--|--|---|---|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>WILLAVENE D ROSSER  |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>NOVEMBER 22, 1982               |   | 2b. HOUR<br>4:10 P. M.  |  |   |  |
| 3. SEX<br>Female   |  | 4. RACE<br>White   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>Feb. 3, 1915  |   | 6. AGE (IN YEARS (LAST BIRTHDAY))<br>67 YRS.   |   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>West Virginia   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Allegany MD.   |   |  |
| 10. CITY OR TOWN OF DEATH<br>CUMBERLAND  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>MEMORIAL HOSPITAL |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Clerk-Retired   |   | 12b. KIND OF BUSINESS OR INDUSTRY<br>Novelty Store   |   |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br>Md.  |  |  | 13b. COUNTY<br>Allegany  |   | 13c. CITY OR TOWN<br>Cumberland                                       |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Michael H. De Witt   |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Opal A. Glover        |   |   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>no   |  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>216-09-1102 |   | 17. INFORMANT<br>ADDRESS<br>Mr. Robert L. Rosser, Cumberland, Husband |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <i>Bronchogenic Carcinoma</i><br>1629<br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>18 |  |  |  |   |   |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: 0   |  |  |  |   |   |  |   |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |   |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT HOME <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |   |  |   |  |
| 22a. I certify that (I (this hospital) attended the deceased from 11/11/82 to 11/22/82, that (we) last saw the deceased alive on 11/22/82, and that in (my) (our) opinion death occurred on the date and hour and from the cause stated above (I) (we) (did) did not view the body after death.  |  |  |  |   |   |  |   |  |
| 22b. SIGNATURE<br>W. Guy Fiscus  |  |  |  | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>        |   | 22c. DATE SIGNED<br>11/23/82   |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>DR. W. GUY FISCUS   |  |  |  | 22e. ADDRESS<br>MEMORIAL HOSPITAL MEDICAL BUILDING<br>CUMBERLAND, MD 21502  |   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial   |  | 23b. DATE<br>11-24-1982  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Sunset Memorial Park  |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Cumberland Allegany, Md.   |   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>James F. Scarpelli, Cumberland, Md.  |  |  |  | 25. DATE REC'D. BY REGISTRAR<br>NOV 26 1982   |   |  |   |  |

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

COPIES

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 IN YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 24 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DHMH - 17  
(VR A15 ME (5))  
15M 2/80

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH   |  |                  |  |  |  |   |  |   |  | REG. NO. 2 27107  |  |  |  |                |  |
|---|--|------------------|--|--|--|---|--|---|--|---|--|--|--|----------------|--|
| 1. FOR STATE REGISTRAR  |  |                  |  |  |  |   |  |   |  | 2a. DATE KNOWN OF DEATH   |  | 2b. HOUR   |  |                |  |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST<br>HELEN GREEN SATHOFF   |  |                  |  |  |  |   |  |   |  | 2a. DATE KNOWN OF DEATH ESTIMATED MONTH DAY YEAR<br>11 19 82            |  | 2b. HOUR 5 A M   |  |                |  |
| 3. SEX<br>FEMALE  |  | 4. RACE<br>WHITE |  | 5. DATE OF BIRTH MONTH DAY YEAR<br>DEC 23 1902   |  | 6. AGE (IN YEARS) LAST BIRTHDAY YRS.<br>79                |  | IF UNDER 1 YR. MONTHS DAYS  |  | IF UNDER 24 HRS. HOURS MIN.   |  | 2c. DATE PRONOUNCED DEAD MONTH DAY YEAR<br>11 19 82                              |  | 2d. HOUR 5 A M |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>MARYLAND   |  |                  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA  |  |   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  |   |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>ALLEGANY MD.                             |  |                |  |
| 10. CITY OR TOWN OF DEATH<br>CUMBERLAND   |  |                  |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Memorial Hospital- D.O.A. |  |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>HOUSEWIFE  |  |   |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |                |  |
| 13a. STATE<br>MARYLAND  |  |                  |  | 13b. COUNTY<br>ALLEGANY  |  | 13c. CITY OR TOWN<br>CUMBERLAND                           |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  | 13e. STREET ADDRESS<br>225 HARRISON STREET                              |  |  |  |                |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>THOMAS FITZPATRICK   |  |                  |  |  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>MARTHA UNK  |  |   |  |   |  |  |  |                |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br>NO  |  |                  |  |  |  | 16b. SOCIAL SECURITY NO.                                  |  | 17. INFORMANT ADDRESS<br>MARTHA GEORGE 903 BRADDOCK ROAD CUMBERLAND   |  |   |  |  |  |                |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1 DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u><br>4100 } DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) <u>Hypertensive Heart Disease</u><br>} DUE TO, OR AS A CONSEQUENCE OF<br>(c)   |  |                  |  |  |  |   |  |   |  |   |  |  |  |                |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).   |  |                  |  |  |  |   |  |   |  |   |  |  |  |                |  |
| 19a. DATE OF OPERATION  |  |                  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |  |   |  |   |  |   |  | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |                |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |  |                  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  |   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)   |  |   |  |  |  |                |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  |                  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)  |  |   |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  |  |   |  |  |  |                |  |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . |  |                  |  |  |  |   |  |   |  |   |  |  |  |                |  |
| ACTUAL SIGNATURE <u>Nicholas Giarritta</u> M.D.   |  |                  |  |  |  |   |  | TITLE (SPECIFY) <u>Deputy</u> MEDICAL EXAMINER  |  |   |  | DATE SIGNED <u>11-19-82</u>  |  |                |  |
| EXAMINER'S NAME (TYPE OR PRINT) <u>NICHOLAS GIARRITTA</u>   |  |                  |  |  |  |   |  | ADDRESS <u>90C SETON DR. CUMB.</u>  |  |   |  |  |  |                |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>BURIAL   |  |                  |  | 23b. DATE<br>22NOV 1982  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>MT. HERMAN CEMETERY |  |   |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br>CUMBERLAND ALLEGANY MARYLAND |  |  |  |                |  |
| 24. FUNERAL DIRECTOR NAME<br>SILCOX-MERRITT FUNERAL SERVICE   |  |                  |  |  |  |   |  | ADDRESS<br>404 Decatur St CUMBERLAND MD.  |  | 25a. DATE REC'D. BY REGISTRAR<br>NOV 23 1982                            |  | 25b. REGISTRAR'S SIGNATURE<br><u>John J. Cunniff</u>                             |  |                |  |

BP



*[Faint, illegible handwritten text, possibly a signature or title, located in the center of the page.]*

*[Faint, illegible text at the bottom of the page, possibly a footer or page number.]*

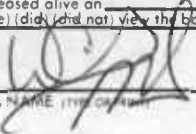


STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 2 7 7 0 8

FOR  
STATE  
REGISTRAR

REG. NO.

|  |  |   |  |   |  |
|--|--|---|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>DEFOREST MAXWELL SEE  |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>NOVEMBER 19, 1982                     |   | 2b. HOUR<br>12:33 P  |
| 3. SEX<br>Male   | 4. RACE<br>White   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>Oct. 24, 1921   | 6. AGE (IN YEARS LAST BIRTHDAY)<br>61 YRS.                                   |   | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>West Virginia   | 7b. CITIZEN OF WHAT COUNTRY?<br>USA  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>ALLEGANY COUNTY MD.                  |   |  |
| 10. CITY OR TOWN OF DEATH<br>Cumberland  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>SACRED HEART HOSPITAL |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Tire Co. |   | 12b. KIND OF BUSINESS OR INDUSTRY  |
| 13a. STATE<br>Maryland   |  | 13b. COUNTY<br>Allegany   | 13c. CITY OR TOWN<br>Cumberland  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Howard See   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Virginia Oglesbee  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>Yes  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>War II 220-07-6346   |  | 17. INFORMANT<br>ADDRESS<br>Mrs. Ruth Ann Dreyer See, Wife                                      |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) 1550 Primary Hepatoma<br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) }<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) } |  |   |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>4 mon  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |   |  |   |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                       | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                    |  |   |  |   |  |
| 22b. SIGNATURE<br>  |  | DEGREE  |  | 22c. DATE SIGNED<br>11/29/82  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>BMG   |  | 22e. ADDRESS<br>BMG, 912 SETON DRIVE, CUMBERLAND, MD 21502  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial   |  | 23b. DATE<br>11-22-1982   | 23c. NAME OF CEMETERY OR CREMATORY<br>Rocky Gap Cemetery                     |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Near Flintstone, Maryland Allegany   |
| 24. FUNERAL DIRECTOR<br>NAME<br>SCARPELLI FUNERAL HOME:  |  | 108 VIRGINIA AVE.,<br>ADDRESS<br>CUMBERLAND, MD 21502   |  | 25. DATE RECEIVED BY REGISTRAR<br>NOV 24 1982   |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH - 16 50M 4/82  
(VRA 15, 4)

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 2 7 7 0 9

1. FOR  
STATE  
REGISTRAR

REG. NO.

|  |   |   |   |  |  |
|--|---|---|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>HELEN EILEEN SEILER</b>   |   |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>NOVEMBER 17, 1982</b>                                 |  | 2b. HOUR<br><b>3:00 PM</b>   |
| 3. SEX<br><b>Female</b>  | 4. RACE<br><b>White</b>   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>Nov. 20, 1919</b>  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>62</b> YRS.   |  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN.   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>   | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>ALLEGANY COUNTY MD.</b>                              |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Cumberland</b>   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>SACRED HEART HOSPITAL</b> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Retired</b>              | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Shoe Store</b>   |  |
| 13a. STATE<br><b>Maryland</b>  | 13b. COUNTY<br><b>Allegany</b>  | 13c. CITY OR TOWN<br><b>Cumberland 21502</b>  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br><b>803 Bedford St.</b>  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>John L. Kerns</b>   |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Sarah F. Foreman</b>  |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>no</b>  |   | 16b. SOCIAL SECURITY NO.<br><b>220-10-1143</b>  |   | 17. INFORMANT<br>ADDRESS<br><b>Mr. Wm. H. Seiler, Cumberland, Md. Husband</b>  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Acute pneumonitis due to</b><br><b>1629</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Oat Cell ca and chemotherapy</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |   |   |   |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |   |   |   |  |  |
| 19a. DATE OF OPERATION   |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |
| 22a. I certify that (I) (the hospital) attended the deceased from <b>10-19, 1982</b> to <b>11-17, 1982</b> that (I) (we) lost<br>saw the deceased alive on <b>11-17, 1982</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above. (I) (we) (did) (did not) view the body after death.  |   |   |   |  |  |
| 22b. SIGNATURE<br><b>Francis W</b>   |   | DEGREE  |   | 22c. DATE SIGNED   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>URIEL VELANDIA, M.D.</b>   |   | 22e. ADDRESS<br><b>924 SETON DRIVE, CUMBERLAND, MD 21502</b>  |   | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>  | 23b. DATE<br><b>11-20-1982</b>  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Sunset Memorial Park</b>   |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Cumberland, Allegany, Md.</b>   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>SCARPELLI FUNERAL HOME: CUMBERLAND, MD 21502</b>  |   | 108 VIRGINIA AVE.,<br>ADDRESS   |   | 25a. DATE REC'D. BY REGISTRAR<br><b>NOV 24 1982</b>  |  |

REGISTRAR'S SIGNATURE  
**John J. Conish**



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |   |  |   |  |  |  |  |  |
|--|--|---|--|---|--|--|--|--|--|
| 1. FOR<br>STATE<br>REGISTRAR   |  |   |  |   | 8 2 2 7 7 1 0<br>REG. NO.  |  |  |  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Allen Lee Sheetz</b>  |  |   |  |   | 2a. DATE OF DEATH<br>MONTH <b>11</b> DAY <b>01</b> YEAR <b>82</b> 2b. HOUR <b>6:15</b> A <b>M</b>  |  |  |  |  |
| 3. SEX<br><b>Male</b>  |  | 4. RACE<br><b>Caucasian</b>   |  | 5. DATE OF BIRTH<br>MONTH <b>01</b> DAY <b>06</b> YEAR <b>1918</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>64</b> YRS.  |  | 7. IF UNDER 1 YEAR<br>MONTHS <b></b> DAYS <b></b> HOURS <b></b> MIN. <b></b> |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Allegany</b> MD                               |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Cumberland</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Lions Manor, Seton Dr. Cumb. MD</b> |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Worker</b>        |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Col. Gas Co.</b>                     |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE <b>Maryland</b> 13b. COUNTY <b>Allegany</b> 13c. CITY OR TOWN <b>Cumberland</b>   |  |   |  |   | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 13e. STREET ADDRESS<br><b>Rt. #5, Box WE 14</b>  |  |  |
| 14. FATHER'S NAME<br>FIRST <b>John</b> MIDDLE <b>Edgar</b> LAST <b>Sheetz</b>  |  |   |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST <b>Olie</b> MIDDLE <b>Barnes</b> LAST <b>Barnes</b>  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>Yes</b>   |  | 16b. SOCIAL SECURITY NO.<br><b>WWII</b>   |  | 17. INFORMANT<br>ADDRESS <b>Rt #5- Box WE 14</b><br><b>Mrs. Catherine Sheetz Cumberland, Md 21502</b>   |  |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br><b>4360</b> IMMEDIATE CAUSE (a) <b>Respiratory failure</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>Cerebral anoxia</b><br>DUE TO, OR AS A CONSEQUENCE OF (c) <b>Acute cerebrovascular accident</b><br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (c):<br><b>M/ASCV disease Previous CVA.</b> |  |   |  |   |  |  |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. <b>19</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>October 26, 1982</b> , to <b>November 1, 1982</b> , that (I) (we) last saw the deceased alive on <b>November 1, 1982</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |   |  |   |  |  |  |  |  |
| 22b. SIGNATURE<br><b>Ralph P. Erdly MD</b>   |  |   |  |   | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  |  | 22c. DATE SIGNED<br><b>11-1-82</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Ralph P. Erdly, M. D.</b>  |  |   |  |   | 22e. ADDRESS<br><b>44 Scott Court, Cumberland, MD 21502</b>  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>  |  | 23b. DATE<br><b>Nov 3, 1982</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Rest Lawn Me Gardens</b>   |  | 23d. LOCATION<br>CITY OR TOWN <b>LaVale</b> COUNTY <b>Allegany</b> STATE <b>Maryland</b> |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME <b>Silcox-Merriitt Funeral Service, Cumberland, Md</b> ADDRESS <b>404 Decatur St</b>  |  |   |  |   | 25a. REG. BY REGISTRAR<br><b>NOV 3 1982</b>  |  | 25b. REGISTRAR'S SIGNATURE<br><b>John J. Canine</b>  |  |  |

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| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH   |  |          |  |   |  |                                    |  |  |  | REG. NO. 2 2 7 7 1 1                    |  |  |  |
|---|--|----------|--|---|--|------------------------------------|--|--|--|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)   |  | FIRST    |  | MIDDLE  |  | LAST                               |  | 2a. DATE KNOWN OF DEATH  |  | MONTH DAY YEAR                          |  | 2b. HOUR   |  |
| Ruth  |  | Virginia |  | Shillingburg  |  |                                    |  | 11 6 1982  |  | 7: A M                                  |  |  |  |
| 3. SEX  |  | 4. RACE  |  | 5. DATE OF BIRTH  |  | 6. AGE (IN YEARS)                  |  | IF UNDER 1 YR.   |  | IF UNDER 24 HRS.                        |  | 2c. DATE PRONOUNCED DEAD                                 |  |
| Female  |  | White    |  | Sept. 3 1901  |  | 81 YRS.                            |  |  |  |   |  | 11 6 1982 9: A M   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   |  |          |  | 7b. CITIZEN OF WHAT COUNTRY?  |  |                                    |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  |   |  | 9. BALTIMORE CITY OR COUNTY OF DEATH                     |  |
| Md.   |  |          |  | U. S. A.  |  |                                    |  |  |  |   |  | Allegany MD.   |  |
| 10. CITY OR TOWN OF DEATH   |  |          |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  |                                    |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)  |  |   |  | 12b. KIND OF BUSINESS OR INDUSTRY                        |  |
| Midland   |  |          |  | Railroad St. Midland Md.  |  |                                    |  | Domestic   |  |   |  | Housewife  |  |
| 13a. STATE  |  |          |  | 13b. COUNTY   |  | 13c. CITY OR TOWN                  |  | 13d. INSIDE CITY LIMITS?   |  | 13e. STREET ADDRESS                     |  |  |  |
| Md.   |  |          |  | Allegany  |  | Midland                            |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  | Railroad St. Midland Md.                |  |  |  |
| 14. FATHER'S NAME   |  |          |  | 15. MOTHER'S MAIDEN NAME  |  |                                    |  |  |  |   |  |  |  |
| Earl  |  |          |  | Reynolds  |  |                                    |  | Bertha   |  | Unknown                                 |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)  |  |          |  | 16b. SOCIAL SECURITY NO.  |  |                                    |  | 17. INFORMANT  |  | ADDRESS                                 |  |  |  |
| No  |  |          |  | 212-74-6889   |  |                                    |  | Mrs Joyce Broadwater   |  | Midland Md.                             |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)   |  |          |  |   |  |                                    |  |  |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH             |  |
| PART 1 DEATH WAS CAUSED BY:   |  |          |  |   |  |                                    |  |  |  |   |  |  |  |
| 4140 IMMEDIATE CAUSE (a) Arteriosclerotic Heart disease   |  |          |  |   |  |                                    |  |  |  |   |  |  |  |
| DUE TO, OR AS A CONSEQUENCE OF  |  |          |  |   |  |                                    |  |  |  |   |  |  |  |
| Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.   |  |          |  |   |  |                                    |  |  |  |   |  |  |  |
| (b) coronary arteriosclerosis   |  |          |  |   |  |                                    |  |  |  |   |  |  |  |
| DUE TO, OR AS A CONSEQUENCE OF  |  |          |  |   |  |                                    |  |  |  |   |  |  |  |
| (c) and Emphysema   |  |          |  |   |  |                                    |  |  |  |   |  |  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).   |  |          |  |   |  |                                    |  |  |  |   |  |  |  |
| 19a. DATE OF OPERATION  |  |          |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?   |  |                                    |  |  |  |   |  | 20. AUTOPSY?   |  |
|   |  |          |  |   |  |                                    |  |  |  |   |  | YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |  |          |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR  |  |                                    |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)  |  |   |  |  |  |
|   |  |          |  | P.M. 19   |  |                                    |  |  |  |   |  |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>  |  |          |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)   |  |                                    |  | 21f. LOCATION  |  | CITY OR TOWN                            |  | COUNTY STATE   |  |
|   |  |          |  |   |  |                                    |  |  |  |   |  |  |  |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . |  |          |  |   |  |                                    |  |  |  |   |  |  |  |
| ACTUAL SIGNATURE  |  |          |  | TITLE (SPECIFY)   |  |                                    |  | DATE SIGNED  |  |   |  |  |  |
| Francisco Reyes   |  |          |  | Deputy  |  |                                    |  | 11-6-82  |  |   |  | 21502  |  |
| EXAMINER'S NAME (TYPE OR PRINT)   |  |          |  | ADDRESS   |  |                                    |  |  |  |   |  |  |  |
| Francisco Reyes   |  |          |  | 900 Seton Dr. Cumberland Md.  |  |                                    |  |  |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)   |  |          |  | 23b. DATE   |  | 23c. NAME OF CEMETERY OR CREMATORY |  |  |  | 23d. LOCATION CITY OR TOWN COUNTY STATE |  |  |  |
| Burial  |  |          |  | 11/13/82  |  | Mt. View Cemetery                  |  |  |  | Moscow Mills Allegany Md.               |  |  |  |
| 24. FUNERAL DIRECTOR NAME   |  |          |  | 25a. DATE REC'D. BY REGISTRAR   |  |                                    |  | 25b. REGISTRAR'S SIGNATURE   |  |   |  |  |  |
| Boal Funeral Service, P. A. Lonaconing Md.  |  |          |  | NOV 12 1982   |  |                                    |  | John J. Canine   |  |   |  |  |  |

MEDICAL CERTIFICATION

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, THE EXAMINER SHOULD EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES TO FUNERAL DIRECTOR. PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |  | 8 2 · 2 7 7 1 2   |  |  |  |
|---|--|--|--|---|--|--|--|
| 1. FOR STATE REGISTRAR  |  |  |  | REG. NO.  |  |  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>JOSEPH EARL SIMMS  |  |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>NOVEMBER 3, 1982   |  |  |  |
| 3. SEX<br>MALE  |  |  |  | 2b. HOUR<br>22:55 R   |  |  |  |
| 4. RACE<br>BLACK  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>JAN 2 1898                       |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>83 YRS.  |  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>W.VA.  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U S A                                  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  |  |
| 9. BALTIMORE CITY OR COUNTY OF DEATH<br>ALLEGANY COUNTY MD.   |  |  |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>BARTENDER   |  |  |  |
| 10. CITY OR TOWN OF DEATH<br>CUMBERLAND   |  |  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>PRIVATE CLUB   |  |  |  |
| 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>SACRED HEART HOSPITAL  |  |  |  |   |  |  |  |
| 12c. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |  |  |  |   |  |  |  |
| 13a. STATE<br>MARYLAND  |  | 13b. COUNTY<br>ALLEGANY  |  | 13c. STREET ADDRESS<br>432 PINE AVE. CUMBERLAND, MD. 21502  |  |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>JOSEPH HENRY SIMMS  |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>MARY ELIZABETH YOUNGER   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>NO  |  | 16b. SOCIAL SECURITY NO.<br>217-10-6470                                |  | 17. INFORMANT<br>ADDRESS<br>JOYCE J. SIMMS. 214 S. PENN ST WHEELING, W.VA. 26003  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>CA Pancreas</u><br>1579<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.         |  |  |  |   |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____  |  |  |  |   |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>10-19</u> , 19 <u>82</u> , to <u>11-3</u> , 19 <u>82</u> , that (I) (we) last saw the deceased alive on <u>11-3</u> , 19 <u>82</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |   |  |  |  |
| 22b. SIGNATURE<br><u>L. M. Glick</u>  |  |  |  | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>        |  | 22c. DATE SIGNED<br>11-9-82  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>L. M. GLICK, M.D.  |  |  |  | 22e. ADDRESS<br>BMG, 912 SETON DRIVE, CUMBERLAND, MD. 21502   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>BURIAL  |  | 23b. DATE<br>11-6-82   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>SUNSET MEMORIAL PARK  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>CUMBERLAND ALLEGANY MARYLAND   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>LEASURE/STEIN FUNERAL HOME  |  |  |  | 25a. DATE REC'D. BY REGISTRAR<br>NOV 12 1982  |  | 25b. REGISTRAR'S SIGNATURE<br><u>John J. Conner</u>  |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of once.

BP

1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 2 7 7 1 3

REG. NO.

|  |  |  |  |   |   |  |   |  |   |  |  |
|--|--|--|--|---|---|--|---|--|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>James R. Sleeman</b>   |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>11 14 82</b>   |   |   | 2b. HOUR<br><b>11:35 AM</b>  |   |  |   |  |  |
| 3. SEX<br><b>Male</b>  |  | 4. RACE<br><b>Caucasian</b>  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>3 24 20</b>  |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>62</b> YRS.  |   | 7. IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN.  |   |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>United States</b>   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Allegany County</b> MD.   |   |  |   |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Frostburg</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Frostburg Community Hospital</b> |  |   |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Self Employed</b>   |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Plasterer</b>  |   |  |  |
| 13a. STATE<br><b>Maryland</b>  |  |  | 13b. COUNTY<br><b>Allegany</b>   |   | 13c. CITY OR TOWN<br><b>Frostburg</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET ADDRESS<br><b>Rt. 3 Box 8</b> |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Roy Sleeman</b>   |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Isabel Connor</b>   |   |  |   |  |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>Yes WWII</b>  |  |  | 16b. SOCIAL SECURITY NO.<br><b>215-10-4394</b>   |   | 17. INFORMANT ADDRESS<br><b>D. Nolan 48 Tarn Terrace Frostburg MD 21532</b>   |  |   |  |   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>TRABECULAR CARCINOMA OF LEFT CHEST</b><br><b>1629</b><br>DUE TO, OR AS A CONSEQUENCE OF <b>WALL AND LEFT LUNG</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(b) _____<br>(c) _____<br>DUE TO, OR AS A CONSEQUENCE OF _____<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>1 YEAR</b> |  |  |  |   |   |  |   |  |   |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:<br><b>NONE</b>  |  |  |  |   |   |  |   |  |   |  |  |
| 19a. DATE OF OPERATION<br><b>FEB. 1982</b>   |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>CA OF LEFT CHEST WALL</b>                             |   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)<br><b>N/A</b>   |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. <input checked="" type="checkbox"/> 19               |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)<br><input checked="" type="checkbox"/> |  |   |  |   |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK<br>NOT WHILE <input checked="" type="checkbox"/> AT WORK  |  |  | 21e. PLACE OF INJURY<br>(AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)<br><input checked="" type="checkbox"/> |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE<br><input checked="" type="checkbox"/>                              |  |   |  |   |  |  |
| 22. I certify that (I) (the undersigned) attended the deceased from <b>APRIL 1980</b> to <b>14 NOVEMBER 1982</b> , that (I) (we) last saw the deceased alive on <b>14 NOVEMBER 1982</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.   |  |  |  |   |   |  |   |  |   |  |  |
| 22a. SIGNATURE<br><i>Martin M. Rothstein</i>   |  |  |  |   |   | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |   | 22c. DATE SIGNED<br><b>11/14/82</b>  |   |  |  |
| 22b. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Martin M. Rothstein, M.D.</b>  |  |  |  |   |   | 22d. ADDRESS<br><b>48 Tarn Terrace Frostburg, MD 21532</b>   |   |  |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>  |  |  | 23b. DATE<br><b>11/16/82</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Eckhart Cemetery</b>   |  |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Eckhart Allegany Md.</b>  |   |  |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Durst Funeral Home 57 Frost Ave. Frostburg, MD. 21532</b>   |  |  |  |   |   | 25a. DATE REC'D. BY REGISTRAR<br><b>NOV 19 1982</b>  |   | 25b. REGISTRAR'S SIGNATURE<br><i>John J. Canale</i>  |   |  |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 7 days with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of the death.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |   |  |   | 8 2 2 7 7 1 4   |   |  |  |
|--|---|--|---|---|---|--|--|
| FOR<br>1. STATE REGISTRAR  |   |  |   | REG. NO.  |   |  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>EDGAR M. SMITH Sr.</b>  |   |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>11-5-82</b>   |   | 2b. HOUR<br><b>4:46am</b> M  |  |
| 3. SEX<br><b>M</b>   | 4. RACE<br><b>W</b>                             | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>4 21/1894</b>   |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>88</b> YRS  |   | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Md.</b>  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U. S. A.</b> |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Allegany</b> MD. |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Cumberland</b>   |   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Sacred Heart Hosp.</b> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>retired</b>              |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Coal Miner</b>   |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |   |  |   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   |  |  |
| 13a. STATE<br><b>MD</b>  |   | 13b. COUNTY<br><b>Allegany</b>   |   | 13c. CITY OR TOWN<br><b>Lonaconing</b>  |   | 13e. STREET ADDRESS<br><b>24 Beechwood St.</b>   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Cornealius</b>  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Susan Broadwater</b>   |   |   |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>  |   | 16b. SOCIAL SECURITY NO.<br><b>217-03-1719</b>   |   | 17. INFORMANT ADDRESS<br><b>Mrs Laura Smith Beechwood St Lonaconing</b>                         |   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardiac Arrest</b><br><b>4960</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>COPD, BSCVD.</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b></b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |   |  |   |   |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |   |  |   |   |   |  |  |
| 19a. DATE OF OPERATION   |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                       |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)                  |   |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |   |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>Oct 5, 1980</b> , to <b>Oct. 29, 1982</b> , that (I) (we) lost saw the deceased alive on <b>Oct. 29, 1982</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                                       |   |  |   |   |   |  |  |
| 22b. SIGNATURE<br><b>Shin E. Kim</b>   |   |  |   | DEGREE<br><b>M.D.</b>   |   | 22c. DATE SIGNED<br><b>11/5/82</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Shin E. Kim</b>  |   |  |   | 22e. ADDRESS<br><b>90 Main St. Western port</b>   |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>   |   | 23b. DATE<br><b>11/7/82</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Oak Hill Cemetery</b>                                  |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Lonaconing Allegany Md.</b>   |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Boal Funeral Service Lonaconing Md.</b>   |   |  |   | 25a. DATE REC'D. BY REGISTRAR<br><b>NOV 12 1982</b>   |   | 25b. REGISTRAR'S SIGNATURE<br><b>Joan J. Connel</b>  |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |   |  | 8 2 2 7 7 1 5   |  |  |  |
|---|--|---|--|---|--|--|--|
| 1. FOR STATE REGISTRAR  |  |   |  | REG. NO.  |  |  |  |
| 1. DECEASED NAME (TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>VIRGIL FRANKLIN SMITH  |  |   |  | 2a. DATE OF DEATH MONTH DAY YEAR<br>November 14, 1982   |  |  |  |
| 3. SEX<br>Male  |  |   |  | 2b. HOUR<br>5:10 PM   |  |  |  |
| 4. RACE<br>White  |  | 5. DATE OF BIRTH MONTH DAY YEAR<br>Dec. 7, 1905   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>76 YRS.  |  | IF UNDER 1 YEAR MONTHS DAYS<br>IF UNDER 24 HRS. HOURS MIN.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Keyser, W. Va.   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Allegany MD.   |  |
| 10. CITY OR TOWN OF DEATH<br>Cumberland   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Memorial Hospital |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Retired  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Corp. Celeanese   |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE 13b. COUNTY 13c. CITY OR TOWN<br>W. Va. Mineral Keyser   |  |   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  |  |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>David Smith  |  |   |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>Laura Rudolph   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br>No   |  | 16b. SOCIAL SECURITY NO.<br>214 07 4188   |  | 17. INFORMANT ADDRESS<br>Alminta Simmons Keyser, W. Va.   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>1991 IMMEDIATE CAUSE (a) PROBABLE SEPSIS<br>DUE TO, OR AS A CONSEQUENCE OF (b) OCCULT CARCINOMA<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>DUE TO, OR AS A CONSEQUENCE OF (c)<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>DAYS- |  |   |  |   |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)<br>BURIAL EMBOLISM ASCITES   |  |   |  |   |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)   |  |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  |  |  |  |
| 22a. I certify that (I) (his hospital) attended the deceased from 10/11/82 to 11/14/82, that (I) (we) last saw the deceased alive on 11/12/82, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death.   |  |   |  |   |  |  |  |
| 22b. SIGNATURE<br>Dr. James Raver   |  |   |  | DEGREE<br>MD<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>  |  | 22c. DATE SIGNED<br>11/15/82   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Dr. James Raver  |  |   |  | 22e. ADDRESS<br>Medical Building<br>Memorial Hospital, Cumberland, MD 21502   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial   |  | 23b. DATE<br>18 Nov 82  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Queens Point  |  | 23d. LOCATION<br>Keyser Mineral W. Va.   |  |
| 24. FUNERAL DIRECTOR<br>ALLEN ROTRUCK Keyser, W. Va.  |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br>NOV 22 1982  |  |  |  |
|   |  |   |  | BY REGISTRAR'S SIGNATURE<br>John J. C... ..   |  |  |  |

BP



FOR  
1. STATE  
REGISTRAR

## CERTIFICATE OF DEATH

REG. NO.

|   |  |  |   |   |  |   |  |   |  |  |  |
|---|--|--|---|---|--|---|--|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>Helen May Stallings  |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>11-15-82 |   |  | 2b. HOUR<br>2:20 P  |  |   |  |  |  |
| 3. SEX<br>Female  |  | 4. RACE<br>White   |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>July 13, 1893   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>89<br>YRS.                                 |  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN.                                 |  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA  |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Allegany MD.                          |  |   |  |  |  |
| 10. CITY OR TOWN OF DEATH<br>Cumberland   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Cumberland Nursing Center |   |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Housewife |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>In Own Home  |  |  |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br>Maryland |  |  |   | 13b. COUNTY<br>Allegany   |  | 13c. CITY OR TOWN<br>Cumberland   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br>424 Virginia Ave. |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Frederick Bear  |  |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Anna Woerner   |  |   |  |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>no  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>213-22-3808   |   | 17. INFORMANT<br>Mrs. Wilda Harrison, Daughter  |  |   |  | ADDRESS   |  |  |  |

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Cancer Pancreas

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH

9 Months

1579  
Conditions, if any, which  
gave rise to immediate  
cause (a), stating the  
underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:10

General debility - Old Age

|  |  |  |  |  |  |   |  |
|--|--|--|--|--|--|---|--|
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)       |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 9/2, 1982, to 9/15, 1982, that (I) (we) last saw the deceased alive on 9/15, 1982, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |  |  |   |  |
| 22b. SIGNATURE<br>P. HALMOS  |  |  |  | DEGREE<br>MD   |  | 22c. DATE SIGNED<br>11/16/82  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>P. HALMOS   |  |  |  | 22e. ADDRESS<br>300 Schley St.   |  |   |  |

|   |  |                         |  |   |  |   |  |
|---|--|-------------------------|--|---|--|---|--|
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial              |  | 23b. DATE<br>11-19-1982 |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Mt. Herman Cemetery |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Cumberland, Allegany, Md. |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>James F. Scarpelli, Cumberland, Md. |  |                         |  | 25a. DATE RECEIVED BY REGISTRAR<br>NOV 22 1982            |  | 25b. REGISTRAR'S SIGNATURE<br>J. A. C. C. C.                            |  |





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of the death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH-16 50M 1/81  
(VRA 15, 4)

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  |  |   |  |  |   |  |
|--|--|--|--|--|---|--|--|---|--|
| FOR<br>1 - STATE<br>REGISTRAR  |  |  |  |  | REG. NO.  |  |  |   |  |
| 1 DECEASED NAME<br>(TYPE OR PRINT) <b>Ilda Stemple</b>   |  |  |  |  | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>11/02/82</b>   |  |  |   |  |
| 3 SEX<br><b>female</b>   |  |  |  |  | 2b. HOUR<br><b>9:00 a.m.</b>  |  |  |   |  |
| 4 RACE<br><b>white</b>   |  |  |  |  | 5. DATE OF BIRTH MONTH DAY YEAR<br><b>02 09 03</b>  |  |  |   |  |
| 6 AGE (IN YEARS (LAST BIRTHDAY))<br><b>79</b>  |  |  |  |  | 7. IF UNDER 1 YEAR<br>MONTHS DAYS<br><b>79</b> YRS.   |  |  |   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>West Virginia</b>  |  |  |  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  |  |   |  |
| 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>   |  |  |  |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Allegany Co</b> MD.  |  |  |   |  |
| 10 CITY OR TOWN OF DEATH<br><b>Frostburg</b>   |  |  |  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Frostburg Community Hospital</b>                  |  |  |   |  |
| 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Housewife</b>   |  |  |  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Home</b>  |  |  |   |  |
| 13a. STATE<br><b>MD</b>  |  |  |  |  | 13b. COUNTY<br><b>Allegany</b>  |  |  |   |  |
| 13c. CITY OR TOWN<br><b>Cumberland</b>   |  |  |  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  |  |   |  |
| 13e. STREET ADDRESS<br><b>28 Browning Street</b>   |  |  |  |  |   |  |  |   |  |
| 14 FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Winfield S. Gray</b>   |  |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Bertie A. Beal</b>  |  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>unknown</b>   |  |  |  |  | 16b. SOCIAL SECURITY NO.<br><b>217 10 4326</b>  |  |  |   |  |
| 17 INFORMANT<br><b>J Robison</b>   |  |  |  |  | ADDRESS<br><b>48 Tarn Terrace, Frostburg, MD</b>  |  |  |   |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardiac Failure</b><br>4100<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Coronary heart failure</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>ASHD. &amp;</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |  |  |  |   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>many weeks</b> |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><b>Multiple Myocardial Infarction Diabetes mellitus</b>  |  |  |  |  |   |  |  |   |  |
| 19a. DATE OF OPERATION   |  |  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |  |   |  |
| 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |  |  |  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |  |  |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |  |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>   |  |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  |  |  |  | 21e. PLACE OF INJURY<br>(AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)   |  |  |   |  |
| 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |  |  |  |   |  |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>MAY 1982</b> to <b>11/02/82</b> that (I) (we) lost saw the deceased alive on <b>11/2</b> 19 <b>82</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.   |  |  |  |  |   |  |  |   |  |
| 22b. SIGNATURE<br><b>S.L. Sandhir</b>  |  |  |  |  | DEGREE<br><b>MD</b><br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  |  |   |  |
| 22c. DATE SIGNED<br><b>11/02/82</b>  |  |  |  |  |   |  |  |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Dr. S.L. Sandhir</b>   |  |  |  |  | 22e. ADDRESS<br><b>48 Tarn Terrace, Frostburg, MD. 21532</b>  |  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br><b>Cremation</b>  |  |  |  |  | 23b. DATE<br><b>11-2-82</b>   |  |  |   |  |
| 23c. NAME OF CEMETERY OR CREMATORY<br><b>Rosedale Funeral Chapel</b>   |  |  |  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Martinsburg Berkeley WV</b>  |  |  |   |  |
| 24 FUNERAL DIRECTOR<br>NAME<br><b>Scarpelli Funeral Home</b>   |  |  |  |  | ADDRESS<br><b>CUMBERLAND, MD 21502</b>  |  |  |   |  |
| 25a. DATE REC'D. BY REGISTRAR<br><b>NOV 8 1982</b>   |  |  |  |  | 25b. REGISTRAR'S SIGNATURE<br><b>John J. Smith</b>  |  |  |   |  |

MEDICAL CERTIFICATION

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Frostburg Community Hospital

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Allegany

Department

St. Joseph's Hospital

Thomsonville, MD

Section 4, 1982

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214 10 4326 5 Robinson 48 Tarn Terrace, Frostburg, MD

48 Tarn Terrace, Frostburg, MD. 21532

Dr. S.L. Sandhir

Scanned by Funder Home, 10/10/2010, 10:00 AM  
11-02-82  
Allegany County, Maryland  
Frostburg Community Hospital

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

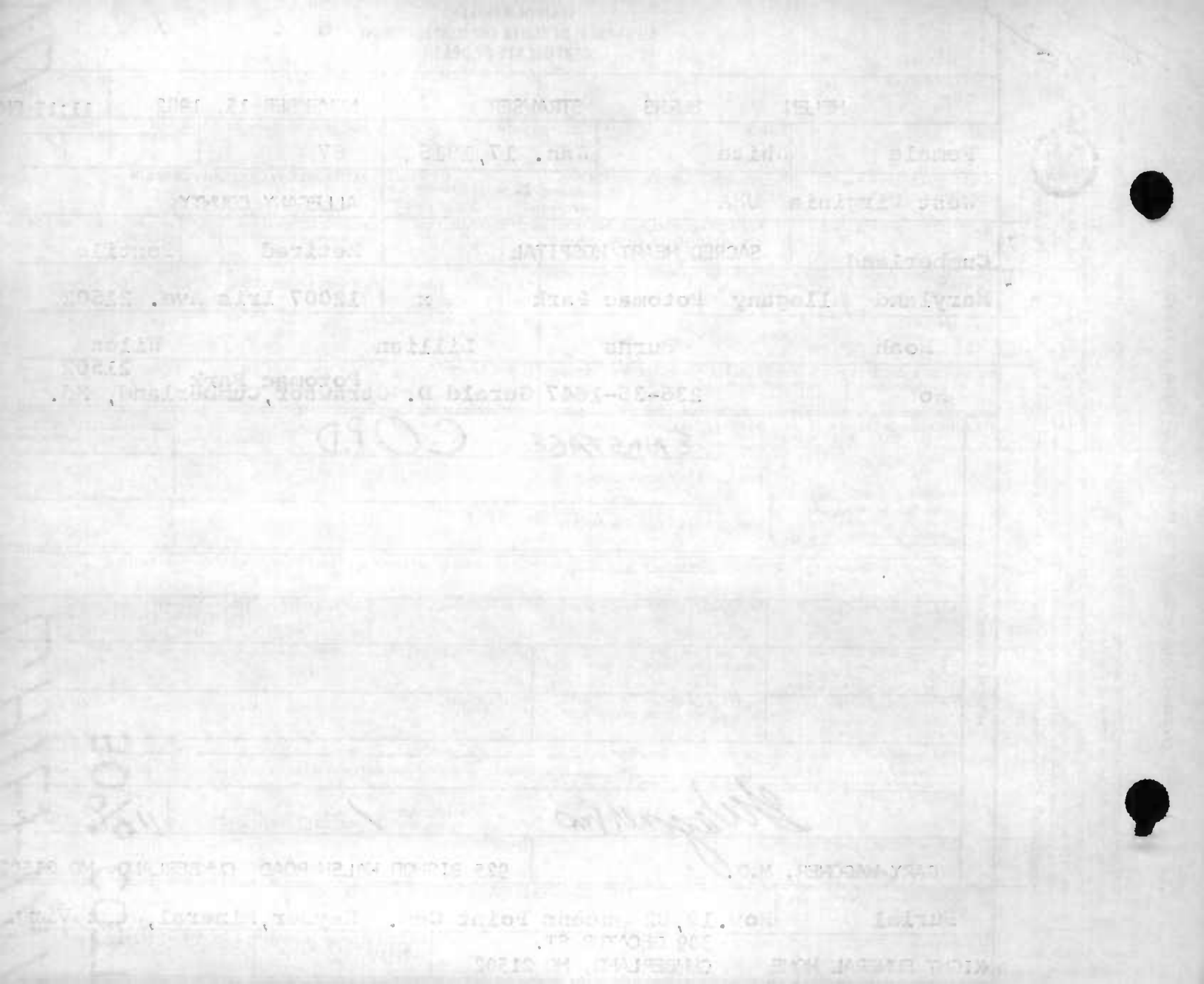
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 7 days with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  | REG. NO. 8 2 2 7 7 1 8  |  |   |  |
|--|--|--|--|---|--|---|--|
| 1. FOR STATE REGISTRAR   |  |  |  | 2a. DATE OF DEATH MONTH DAY YEAR  |  |   |  |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST<br>HELEN BURNS STRAWSER   |  |  |  | NOVEMBER 15, 1982   |  |   |  |
| 2b. HOUR 11:13 PM  |  |  |  |   |  |   |  |
| 3. SEX Female  |  | 4. RACE White  |  | 5. DATE OF BIRTH MONTH DAY YEAR<br>Jan. 17, 1915  |  | 6. AGE (IN YEARS LAST BIRTHDAY) 67 YRS.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>West Virginia   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>ALLEGANY COUNTY, MD.  |  |
| 10. CITY OR TOWN OF DEATH<br>Cumberland  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>SACRED HEART HOSPITAL |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Retired  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Textile  |  |
| 13a. STATE Maryland  |  |  |  | 13b. COUNTY Allegany  |  | 13c. STREET ADDRESS<br>12007 Iris Ave. 21502  |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>Noah Burns  |  |  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>Lillian Wiles   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br>No  |  | 16b. SOCIAL SECURITY NO.<br>236-36-1847  |  | 17. INFORMANT ADDRESS<br>Gerald D. Strawser, Potomac Park, Cumberland, Md. 21502  |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) 4960 ENDSTAGE CORD<br>DUE TO, OR AS A CONSEQUENCE OF (b) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } DUE TO, OR AS A CONSEQUENCE OF (c) _____<br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____ |  |  |  |   |  |   |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART 1 OR PART 2)  |  |   |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) lost _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.   |  |  |  |   |  |   |  |
| 22b. SIGNATURE <i>Gary Wagoner</i>   |  |  |  | DEGREE  |  | 22c. DATE SIGNED 11-16-82   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>GARY WAGONER, M.D.  |  |  |  | 22e. ADDRESS<br>925 BISHOP WALSH ROAD CUMBERLAND, MD 21502  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial  |  | 23b. DATE<br>Nov. 19, 82   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Queens Point Cem.   |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br>Keyser, Mineral, West Virginia   |  |
| 24. FUNERAL DIRECTOR NAME<br>KIGHT FUNERAL HOME  |  | 309 DECATUR ST.<br>CUMBERLAND, MD 21502  |  | 25a. DATE REC'D BY REGISTRAR<br>NOV 22 1982   |  | 25b. REGISTRAR'S SIGNATURE <i>Gary Wagoner</i>  |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |   |  | 8 2 2 7 7 1 9   |  |  |  |
|---|--|---|--|---|--|--|--|
| 1. FOR STATE REGISTRAR  |  |   |  | REG. NO.  |  |  |  |
| 1. DECEASED NAME (TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>JOSEPH ELMER SWEITZER  |  |   |  | 2a. DATE OF DEATH MONTH DAY YEAR<br>NOVEMBER 19, 1982   |  |  |  |
| 2b. HOUR<br>04:10 AM  |  |   |  |   |  |  |  |
| 3. SEX<br>MALE  |  | 4. RACE<br>WHITE  |  | 5. DATE OF BIRTH MONTH DAY YEAR<br>5/5/11   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>70 YRS.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>MARYLAND   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>ALLEGANY COUNTY, MD.   |  |
| 10. CITY OR TOWN OF DEATH<br>CUMBERLAND   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>SACRED HEART HOSPITAL |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>OWNER-OPERATOR   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>RESTAURANT, BAR   |  |
| 13a. STATE<br>MARYLAND  |  |   |  | 13b. COUNTY<br>ALLEGANY   |  | 13c. CITY OR TOWN<br>FROSTBURG   |  |
| 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  |   |  | 13e. STREET ADDRESS<br>89 OAK STREET  |  |  |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>GEORGE SWEITZER  |  |   |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>MARY E.B. DONEGAN   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, GIVE WAR OR DATES)<br>YES  |  | 16b. SOCIAL SECURITY NO.<br>WW 11 214007-3645   |  | 17. INFORMANT ADDRESS<br>MRS. JOSEPH E. SWEITZER, 89 OAK ST., FROSTBURG, MD. 21532  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I: DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>C.H.F. pulmonary edema</u><br>DUE TO, OR AS A CONSEQUENCE OF (b) <u>Renal insufficiency.</u><br>DUE TO, OR AS A CONSEQUENCE OF (c) <u>Cerebral arterial bleeding.</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |   |  |   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>CONTRIBUTING TO DEATH</u>   |  |   |  |   |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>11-8</u> , 19 <u>82</u> , to <u>11-19</u> , 19 <u>82</u> , that (I) (we) lost saw the deceased alive on <u>11-19</u> , 19 <u>82</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |   |  |   |  |  |  |
| 22b. SIGNATURE <u>Uriel Velandia</u> DEGREE <u>MD</u>   |  |   |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>                  |  | 22c. DATE SIGNED   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>URIEL VELANDIA, M.D.   |  |   |  | 22e. ADDRESS<br>924 SETON DR., CUMBERLAND, MD 21502   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>BURIAL   |  | 23b. DATE<br>11/22/82   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>FROSTBURG MEM. PARK   |  | 23d. LOCATION CITY COUNTY STATE<br>FROSTBURG ALLEGANY MD.  |  |
| 24. FUNERAL DIRECTOR<br>SOWERS FUNERAL HOME   |  | 40 W. MAIN STREET<br>FROSTBURG, MD 21532  |  | 25a. DAY, MONTH, YEAR RECEIVED BY REGISTRAR<br>NOV 26 1982  |  |  |  |

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| NAME                           | DATE OF BIRTH | DATE OF DEATH | PLACE OF BIRTH | PLACE OF DEATH | CAUSE OF DEATH | DATE OF BURIAL | PLACE OF BURIAL | DATE OF CREMATION | PLACE OF CREMATION | DATE OF INTERMENT | PLACE OF INTERMENT |
|--------------------------------|---------------|---------------|----------------|----------------|----------------|----------------|-----------------|-------------------|--------------------|-------------------|--------------------|
| GEORGE                         | 1911-07-21    | 1984-07-21    | NEW YORK, N.Y. | NEW YORK, N.Y. | HEART DISEASE  | 1984-07-21     | NEW YORK, N.Y.  | 1984-07-21        | NEW YORK, N.Y.     | 1984-07-21        | NEW YORK, N.Y.     |
| MARYLAND                       | 1911-07-21    | 1984-07-21    | NEW YORK, N.Y. | NEW YORK, N.Y. | HEART DISEASE  | 1984-07-21     | NEW YORK, N.Y.  | 1984-07-21        | NEW YORK, N.Y.     | 1984-07-21        | NEW YORK, N.Y.     |
| ALLBANY                        | 1911-07-21    | 1984-07-21    | NEW YORK, N.Y. | NEW YORK, N.Y. | HEART DISEASE  | 1984-07-21     | NEW YORK, N.Y.  | 1984-07-21        | NEW YORK, N.Y.     | 1984-07-21        | NEW YORK, N.Y.     |
| FOSTERBURG                     | 1911-07-21    | 1984-07-21    | NEW YORK, N.Y. | NEW YORK, N.Y. | HEART DISEASE  | 1984-07-21     | NEW YORK, N.Y.  | 1984-07-21        | NEW YORK, N.Y.     | 1984-07-21        | NEW YORK, N.Y.     |
| OWNER-OPERATOR RESTAURANT, BAR | 1911-07-21    | 1984-07-21    | NEW YORK, N.Y. | NEW YORK, N.Y. | HEART DISEASE  | 1984-07-21     | NEW YORK, N.Y.  | 1984-07-21        | NEW YORK, N.Y.     | 1984-07-21        | NEW YORK, N.Y.     |
| FOOTING                        | 1911-07-21    | 1984-07-21    | NEW YORK, N.Y. | NEW YORK, N.Y. | HEART DISEASE  | 1984-07-21     | NEW YORK, N.Y.  | 1984-07-21        | NEW YORK, N.Y.     | 1984-07-21        | NEW YORK, N.Y.     |
| MARYLAND                       | 1911-07-21    | 1984-07-21    | NEW YORK, N.Y. | NEW YORK, N.Y. | HEART DISEASE  | 1984-07-21     | NEW YORK, N.Y.  | 1984-07-21        | NEW YORK, N.Y.     | 1984-07-21        | NEW YORK, N.Y.     |
| U.S.A.                         | 1911-07-21    | 1984-07-21    | NEW YORK, N.Y. | NEW YORK, N.Y. | HEART DISEASE  | 1984-07-21     | NEW YORK, N.Y.  | 1984-07-21        | NEW YORK, N.Y.     | 1984-07-21        | NEW YORK, N.Y.     |
| MALE                           | 1911-07-21    | 1984-07-21    | NEW YORK, N.Y. | NEW YORK, N.Y. | HEART DISEASE  | 1984-07-21     | NEW YORK, N.Y.  | 1984-07-21        | NEW YORK, N.Y.     | 1984-07-21        | NEW YORK, N.Y.     |

11/22/82 PROSTBURG MSH. PARK PROSTBURG ALLEGANY MD. RUN IAL



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS ANTICIPATED, THE EXAMINER SHOULD EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE REGISTRAR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 1 FOR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED IN THE FILES. AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

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(VR A15 ME (5))  
15M 2/80

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH   |  |   |  |  |  |   |  |  |  | REG. NO. 8 2 2 7 7 2 0   |  |  |  |
|---|--|---|--|--|--|---|--|--|--|--|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) <b>John J. Testa</b>   |  |   |  |  |  | 2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> ESTIMATED <input type="checkbox"/> <b>11-28 19 82</b> |  | 2b. HOUR <b>10a</b>  |  | 2c. DATE PRONOUNCED DEAD <b>Nov. 28 19 82</b>                                  |  | 2d. HOUR <b>10a</b>  |  |
| 3. SEX <b>Male</b>  |  | 4. RACE <b>White</b>                        |  | 5. DATE OF BIRTH <b>June 24, 1913</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY) <b>69 YRS.</b>  |  | 7. IF UNDER 1 YR. MONTHS DAYS  |  | 7. IF UNDER 24 HRS. HOURS MIN.   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Pennsylvania</b>   |  |   |  | 7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>  |  |   |  | 9. BALTIMORE CITY OR COUNTY OF DEATH <b>Allegany</b>   |  |  |  |  |  |
| 10. CITY OR TOWN OF DEATH <b>Cumberland</b>   |  |   |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Route 4, Mexico Farms</b> |  |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Retired</b>                 |  |  |  | 12b. KIND OF BUSINESS OR INDUSTRY <b>Construction</b>  |  |
| 13a. STATE <b>Maryland</b>  |  |   |  | 13b. COUNTY <b>Allegany</b>  |  | 13c. CITY OR TOWN <b>Cumberland</b>   |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET ADDRESS <b>Route 4, Mexico Farms</b>                               |  |  |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST <b>Luigi Testa</b>  |  |   |  |  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Lavorina Camellia</b>   |  |  |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>Yes</b>   |  | 16b. SOCIAL SECURITY NO. <b>175-18-7102</b> |  | 17. INFORMANT <b>Mrs. Helen Testa, Cumberland, Md. Wife</b>  |  | 17. ADDRESS   |  |  |  |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br><b>2312</b> IMMEDIATE CAUSE (a) <b>Respiratory Insufficiency</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.<br>(b) <b>Squamous Carcinoma of Lung</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____   |  |   |  |  |  |   |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>sudden</b><br><b>1 year</b> |  |  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).   |  |   |  |  |  |   |  |  |  |  |  |  |  |
| 19a. DATE OF OPERATION  |  |   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |  |   |  | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>             |  |  |  |  |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |  |   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)                                     |  |  |  |  |  |  |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  |   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)  |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  |  |  |  |  |  |  |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . |  |   |  |  |  |   |  |  |  |  |  |  |  |
| ACTUAL SIGNATURE <b>Dr. Paul Snow</b>   |  |   |  | TITLE (SPECIFY) <b>Deputy Asst.</b>  |  |   |  | DATE SIGNED <b>11-29-1982</b>  |  |  |  |  |  |
| EXAMINER'S NAME (TYPE OR PRINT) <b>Dr. Paul Snow</b>  |  |   |  | ADDRESS  |  |   |  |  |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>   |  |   |  | 23b. DATE <b>Dec. 1, 1982</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY <b>Sunset Memorial Park</b>  |  | 23d. LOCATION CITY OR TOWN COUNTY STATE <b>Cumberland, Allegany, Md.</b>                     |  |  |  |  |  |
| 24. FUNERAL DIRECTOR NAME <b>James F. Scarpelli, Cumberland, Md.</b>  |  |   |  |  |  | 25a. DATE REC'D. BY REGISTRAR <b>DEC 7 1982</b>   |  | 25b. REGISTRAR'S SIGNATURE <b>John J. Camuff</b>   |  |  |  |  |  |

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

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1. FOR  
STATE  
REGISTRAR

REG. NO.

|   |  |   |  |   |                                  |  |  |
|---|--|---|--|---|----------------------------------|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>MABEL MARGARET THOMAS</b>                      |  |   | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>November 10, 1982</b> |   | 2b. HOUR<br><b>8:08</b><br>A. M. |  |  |
| 3. SEX<br><b>FEMALE</b>   |  | 4. RACE<br><b>WHITE</b>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>MARCH 13 1915</b>  |                                  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>67</b> YRS.                                |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>MARYLAND</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |                                  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>ALLEGANY</b> MD.                      |  |
| 10. CITY OR TOWN OF DEATH<br><b>CUMBERLAND</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>MEMORIAL HOSPITAL</b> |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>HOSPITAL-NURSES AIDE</b>   |                                  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |
| 13a. STATE<br><b>MARYLAND</b>   |  |   |  | 13b. COUNTY<br><b>ALLEGANY</b>  |                                  | 13c. CITY OR TOWN<br><b>CUMBERLAND</b>   |  |
| 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>               |  |   |  | 13e. STREET ADDRESS<br><b>407 DECATUR STREET</b>  |                                  |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>JAMES P. KELLEY</b>  |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>MARY GERTRUDE SEIFERS</b>   |                                  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>NO</b> |  |   |  | 16b. SOCIAL SECURITY NO.<br><b>215-16-4903</b>  |                                  | 17. INFORMANT<br>ADDRESS<br><b>BARBARA JOHNSON RFD 5 BOX # TWI CUMBERLAND MD</b> |  |

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).  
PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

**5770**

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which  
gave rise to immediate  
cause (a), stating the  
underlying cause last

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:

**D.M. abd. abscess, liver, Hydrops, gallbladder**

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED

20a. AUTOPSY?

YES ☐ NO ☒20b. IF YES, WERE FINDINGS USED  
IN CERTIFYING CAUSES OF DEATH?YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐  
OR CONTRIBUTING ☐ CAUSE OF DEATH  
(IF EITHER, NOTIFY MEDICAL EXAMINER)

21b. TIME OF INJURY  
HOUR A.M. MONTH DAY YEAR  
P.M. 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)

21d. INJURY OCCURRED  
WHILE ☐ NOT WHILE ☐  
AT WORK AT WORK

21e. PLACE OF INJURY  
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)

21f. LOCATION  
STREET

CITY OR TOWN

COUNTY

STATE

22a. I certify that (1) (this hospital) attended the deceased from **8-20-82**, 19 **82**, to **11-10**, 19 **82**, that (1) (we) lost  
saw the deceased alive on **11-9**, 19 **82**, and that in my (our) opinion death occurred on the date and hour and from the causes stated  
above, (1) (we) (did) (did not) view the body after death.

22b. SIGNATURE

DEGREE

ATTENDING  
PHYSICIANMEDICAL  
DIRECTORSTAFF  
PHYSICIAN

22c. DATE SIGNED

**11-10-82**

22d. PHYSICIAN'S NAME (TYPE OR PRINT)

22e. ADDRESS

**DR. ANTHONY BOLLINO**

**955 Frederick St.  
Cumberland, Maryland**

**21502**23a. BURIAL, CREMATION, REMOVAL  
(SPECIFY)

23b. DATE

23c. NAME OF CEMETERY OR CREMATORY

23d. LOCATION  
CITY OR TOWN

COUNTY

STATE

**BURIAL****NOV 13 1982****SUNSET MEMORIAL PARK****CUMBERLAND****ALLEGANY MARYLAND**

24. FUNERAL DIRECTOR

25a. DATE REC'D. BY REGISTRAR

25b. REGISTRAR'S SIGNATURE

**SILCOX-MERRITT FUNERAL SERVICE CUMBERLAND MD.****NOV 15 1982****John J. Smith**

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |   |  | 8 2 2 7 7 2 2  |  |  |  |
|--|--|---|--|--|--|--|--|
| 1. STATE REGISTRAR   |  |   |  | REG. NO.   |  |  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>JAMES WILLIAM TYREE</b>   |  |   |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>NOVEMBER 2, 1982</b>   |  | 2b. HOUR<br><b>05:40 AM</b>  |  |
| 3. SEX<br><b>MALE</b>  | 4. RACE<br><b>WHITE</b>                    | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>AUG 31 1902</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>80</b> YRS.  |  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>VIRGINIA</b>   | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b> | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>ALLEGANY COUNTY, MD.</b>  |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>RFD6 CUMBERLAND</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>SACRED HEART HOSPITAL</b>                   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>RETIRED CELENESE ELECTRICAL</b>   |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |  |   |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |  |  |
| 13a. STATE<br><b>MARYLAND</b>  | 13b. COUNTY<br><b>ALLEGANY</b>             | 13c. CITY OR TOWN<br><b>CUMBERLAND</b>  |  | 13e. STREET ADDRESS<br><b>RFD#6 BOX#346 HAROLD DRIVE 21502</b>   |  |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>DANIEL W. TYREE</b>   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>NANNIE ELIZABETH DRAIN</b>  |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>NO</b>  |  | 16b. SOCIAL SECURITY NO.<br><b>214-07-4217</b>  |  | 17. INFORMANT<br>ADDRESS<br><b>VERONICA TYREE RFD#6 HAROLD DRIVE CUMBERLAND</b>  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br><b>1629</b> IMMEDIATE CAUSE (a) <b>Broncho pneumonia</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>Metastatic oat cell ca</b><br>DUE TO, OR AS A CONSEQUENCE OF (c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. |  |   |  |  |  |  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) _____   |  |   |  |  |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>10-19</b> , 19 <b>82</b> , to <b>11-2</b> , 19 <b>82</b> , that (I) (we) lost saw the deceased dying on <b>11-1</b> , 19 <b>82</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                    |  |   |  |  |  |  |  |
| 22b. SIGNATURE<br><i>Uriel Velandia</i> W  |  |   |  | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>URIEL VELANDIA, M.D.</b>   |  |   |  | 22e. ADDRESS<br><b>924 SETON DR., CUMBERLAND, MD 21502</b>   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>SPECIES<br><b>BURIAL</b>  |  | 23b. DATE<br><b>NOV 5 1982</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>HILLCREST BURIAL PARK</b>   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>CUMBERLAND ALLEGANY MARYLAND</b>  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>SILCOX-MERRITT FUNERAL HOME</b>   |  |   |  | 24b. ADDRESS<br><b>404 DECATUR STREET CUMBERLAND, MD 21502</b>   |  |  |  |
| DATE REC'D. BY REGISTRAR<br><b>NOV 5 1982</b>  |  |   |  | REGISTRAR'S SIGNATURE<br><i>John J. Casper</i>   |  |  |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the Medical Examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |   |  | 8 2 2 7 7 2 3   |  |  |  |
|---|--|---|--|---|--|--|--|
| 1. FOR STATE REGISTRAR  |  |   |  | REG. NO.  |  |  |  |
| 1. DECEASED NAME (TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>ROSALIE HOMAN VANDIVER   |  |   |  | 2a. DATE OF DEATH MONTH DAY YEAR<br>NOVEMBER 5, 1982  |  | 2b. HOUR<br>9:35 PM  |  |
| 3. SEX<br>Female  |  | 4. RACE<br>White  |  | 5. DATE OF BIRTH MONTH DAY YEAR<br>August 23, 1890  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>92 YRS.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>W. Va.   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>ALLEGANY COUNTY MD.  |  |
| 10. CITY OR TOWN OF DEATH<br>Cumberland   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>SACRED HEART HOSPITAL |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Homemaker  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Own Home  |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE W. Va. 13b. COUNTY Mineral 13c. CITY OR TOWN Burlington  |  |   |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 13e. STREET ADDRESS  |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>Henry Crowder Homan  |  |   |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>Margaret -- Wilson  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br>No   |  | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)<br>None  |  | 17. INFORMANT ADDRESS<br>Mrs. Jean Bishoff, 310 S. Main St. Moorefield, W. Va.  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>4360 IMMEDIATE CAUSE (a) CVA<br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____ |  |   |  |   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>12 hrs |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)   |  |   |  |   |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)  |  |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 11-5-82, 19____, to 11-5-82, 19____, that (I) (we) last saw the deceased alive on 11-5-82, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.            |  |   |  |   |  |  |  |
| 22b. SIGNATURE<br>Paul T. Livengood MD  |  |   |  | DEGREE<br>MD  |  | 22c. DATE SIGNED<br>11-8-82  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>PAUL T. LIVENGOOD MD   |  |   |  | 22e. ADDRESS<br>BMG, 912 SETON DRIVE, CUMBERLAND, MD 21502  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial   |  | 23b. DATE<br>Nov. 8, 1982   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Burlington Cemetery   |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br>Burlington Mineral W. Va.   |  |
| 24. FUNERAL DIRECTOR'S NAME (TYPE OR PRINT)<br>Homer W. McKeen II<br>MARKWOOD FUNERAL HOME: KEYSER WVA 26726  |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br>NOV 12 1982  |  | 25b. REGISTRAR'S SIGNATURE<br>John E. Carver   |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |   |  | 8 2 2 7 7 2 4   |  |   |  |
|---|--|---|--|---|--|---|--|
| 1. FOR STATE REGISTRAR  |  |   |  | REG. NO.  |  |   |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>ELLA MAE VARNER</b>  |  |   |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>NOVEMBER 28, 1982</b>   |  | 2b. HOUR<br><b>12:20 AM</b>   |  |
| 3. SEX<br><b>Female</b>   |  | 4. RACE<br><b>White</b>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>June 8, 1910</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>72</b><br>YRS. MONTHS DAYS  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>W. Va.</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U. S. A.</b>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>ALLEGANY COUNTY</b> MD.  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Cumberland,</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>SACRED HEART HOSPITAL</b> |  | 12a. USUAL OCCUPATION<br>(STATE OF WORK FOR MOST OF WORKING LIFE)<br><b>Domestic,</b>   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Own Home</b>  |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE <b>Maryland</b> 13b. COUNTY <b>Allegany</b> 13c. CITY OR TOWN <b>Cumberland,</b>   |  |   |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>David -- Varner</b>  |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Delphia -- Johnson</b>  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) <b>No,</b> IF YES, GIVE WAR OR DATES   |  | 16b. SOCIAL SECURITY NO.  |  | 17. INFORMANT ADDRESS<br><b>Mrs. Mary Jane Paden, 472 Balto. Ave. Cumb. Md. 21502</b>   |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br><b>4100 VENTRICULAR FIBRILLATION</b><br>IMMEDIATE CAUSE (a) <b>4100</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last:<br>(b) <b>MYOCARDIAL INFARCTION</b><br>(c) <b>CORONARY ARTERY DISEASE</b> |  |   |  |   |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>MIB</b><br><b>NMS</b><br><b>YES</b> |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>N/A.</b>  |  |   |  |   |  |   |  |
| 19a. DATE OF OPERATION<br><b>N/A.</b>   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>N/A.</b>   |  | 20a. AUTOPSY<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED CERTIFYING CAUSE OF DEATH?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)<br><input type="checkbox"/>  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>N/A.</b>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)<br><b>N/A.</b>   |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)<br><b>N/A.</b>   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE<br><b>N/A.</b>  |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>NOV 24</b> , 19 <b>82</b> , to <b>NOV 28</b> , 19 <b>82</b> , that (I) (we) lost saw the deceased alive on <b>NOV 28</b> , 19 <b>82</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) see the body after death.                           |  |   |  |   |  |   |  |
| 22b. SIGNATURE<br><b>B. D. Behounek</b>   |  |   |  | DEGREE<br><b>M.D.</b>   |  | 22c. DATE SIGNED<br><b>11/29/82</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>BRUCE D. BEHOUNEK, M.D.</b>   |  |   |  | 22e. ADDRESS<br><b>BMG-912 SETON DRIVE CUMBERLAND, MD 21502</b>   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>  |  | 23b. DATE<br><b>12/1/82</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Hillcrest Burial Park, Cumberland, Allegany Maryland</b>   |  | 23d. LOCATION   |  |
| 24. FUNERAL HOME<br>NAME<br><b>George George</b>  |  | 24b. ADDRESS<br><b>202 GREENE STREET CUMBERLAND, MD 21502</b>   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>DEC 6 1982</b>  |  | 25b. REGISTRAR'S SIGNATURE<br><b>John J. Conish</b>   |  |

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CHIFFON



NEW YORK  
100 GARDEN STREET  
NEW YORK, N.Y. 10002

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NEW YORK  
100 GARDEN STREET  
NEW YORK, N.Y. 10002

STATE OF MARYLAND  
 DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
 CERTIFICATE OF DEATH

8 2 2 7 7 2 5

1. FOR  
STATE  
REGISTRAR

REG. NO.

|   |  |   |   |  |  |
|---|--|---|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) FIRST MIDDLE LAST<br>ETTA MAE VINCENT   |  |   | 2a. DATE OF DEATH MONTH DAY YEAR<br>NOVEMBER 1, 1982  |  | 2b. HOUR<br>9:15<br>P. M.  |
| 3. SEX<br>Female  | 4. RACE<br>White   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>Jan. 5, 1908  |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br>74 YRS.   | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN.   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland   | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Allegany MD                                  |  |
| 10. CITY OR TOWN OF DEATH<br>CUMBERLAND   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>MEMORIAL HOSPITAL |   |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Homemaker        | 12b. KIND OF BUSINESS OR INDUSTRY<br>Own Home  |
| 13a. STATE<br>Maryland  | 13b. COUNTY<br>Allegany  | 13c. CITY OR TOWN<br>Mt. Savage   | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 13e. STREET ADDRESS<br>Rt. 1, Box 157  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Henry J. Bennett  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Pluma Lashley  |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br>No  |  | 16b. SOCIAL SECURITY NO.<br>212-18-1764   |   | 17. INFORMANT<br>ADDRESS 922 Weirs Ave.<br>Mrs. Sally Sherry La Vale, Md.            |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for the terminal disease and any other conditions which contributed to death. Part 1: DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cardiopulmonary Arrest</u><br>4280<br>DUE TO, OR AS A CONSEQUENCE OF (b) <u>Myocardial CVA</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>CHF, CAD</u><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |   |   |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)  |  |   |   |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)       |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |  |
| 22a. I certify that (I) (this hospital) saw the deceased from above (I) (we) (did) (did not) see the body after death. Nov. 1, 1982, to Nov. 1, 1982, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated   |  |   |   |  |  |
| 22b. SIGNATURE<br>Dr. Anthony Bollino   |  | DEGREE<br>M.D.  |   | 22c. DATE SIGNED<br>11-3-82  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>DR. ANTHONY BOLLINO  |  | 22e. ADDRESS<br>MEMORIAL HOSPITAL MEDICAL BUILDING<br>CUMBERLAND, MD 21502  |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial   |  | 23b. DATE<br>Nov. 3, 1982   | 23c. NAME OF CEMETERY OR CREMATORY<br>Methodist Cemetery Mt. Savage, Maryland                   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE   |
| 24. FUNERAL DIRECTOR<br>NAME<br>Durst Funeral Home, Frostburg, Md.  |  | 25a. DATE REC'D. BY REGISTRAR<br>NOV 10 1982  |   | 25b. REGISTRAR'S SIGNATURE<br>John J. Connel   |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or after traumatic event, the medical examiner must be notified at once.

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UNITED STATES DEPARTMENT OF JUSTICE  
FEDERAL BUREAU OF INVESTIGATION  
WASHINGTON, D. C. 20535

TO : DIRECTOR, FBI  
FROM : SAC, NEW YORK  
SUBJECT: [Illegible]  
RE: [Illegible]

CONFIDENTIAL  
JAN 19 1961

ALIVE

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CONFIDENTIAL  
JAN 19 1961

CONFIDENTIAL



FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 2 7 1 2 6

REG. NO.

|  |   |  |  |  |  |
|--|---|--|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Nellie Pearl Virts</b>  |   |  | 2a. DATE OF DEATH<br>MONTH <b>NOV</b> DAY <b>2</b> YEAR <b>82</b>                    |  | 2b. HOUR<br><b>3 45</b> M  |
| 3. SEX<br><b>FEMALE</b>  | 4. RACE<br><b>WHITE</b>   | 5. DATE OF BIRTH<br>MONTH <b>NOV</b> DAY <b>1</b> YEAR <b>1887</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>95</b>   | IF UNDER 1 YEAR<br>MONTHS <b>0</b> DAYS <b>0</b>   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>MD.</b>  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>    |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>ALLEGANY</b> MD.                          |  |
| 10. CITY OR TOWN OF DEATH<br><b>Cumberland</b>   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Cumberland Nursing Center</b> |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>HOUSEWIFE</b> |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>_____   |
| 13a. STATE<br><b>MARYLAND</b>  |   |  | 13b. COUNTY<br><b>ALLEGANY</b>   | 13c. CITY OR TOWN<br><b>CUMBERLAND</b>   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                            |
| 14. FATHER'S NAME<br>FIRST <b>WALTER</b> MIDDLE <b>B.</b> LAST <b>CLARK</b>  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST <b>KATHERINE</b> MIDDLE <b>RIDENOUR</b>            |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES OR UNKNOWN) <b>NO</b>   |   | 16b. SOCIAL SECURITY NO.<br><b>220-03-7105</b>   |  | 17. INFORMANT<br>ADDRESS <b>SALLY GOSS 117 EAST OFFUTT ST CUMBERLAND MD.</b>         |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Intestinal obstruction</b><br><b>5609</b><br>DUE TO, OR AS A CONSEQUENCE OF (b)<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>DUE TO, OR AS A CONSEQUENCE OF (c) |   |  |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: _____   |   |  |  |  |  |
| 19a. DATE OF OPERATION   |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)       |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>11/1</b> 19 <b>82</b> , to <b>11/2</b> 19 <b>82</b> , that (I) (we) lost <b>the deceased</b> on <b>11/1</b> 19 <b>82</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |   |  |  |  |  |
| 22b. SIGNATURE<br><b>P.B. HALMOS</b>   |   | DEGREE <b>MD</b><br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED<br><b>11/3/82</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>P.B. HALMOS</b>  |   | 22e. ADDRESS<br><b>302 Schlegel Cumberland.</b>  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>BURIAL</b>   |   | 23b. DATE<br><b>NOV 4, 1982</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>ROSEHILL MAUSOLEUM</b>                      |  |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>CUMBERLAND ALLEGANY MARYLAND</b>  |   | 23e. DATE REC'D. BY REGISTRAR<br><b>NOV 8 1982</b>   |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME <b>SILCOX-MERRITT FUNERAL SERVICE CUMBERLAND MD.</b><br>ADDRESS _____   |   |  |  |  |  |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon copiers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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2007-20-022

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29 p321 1 vol 3100 3111-7

Time: 1:15

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 2 7 7 2 7

1. FOR  
STATE  
REGISTRAR

REG. NO.

|   |  |  |   |   |                      |  |
|---|--|--|---|---|----------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>ELIZABETH ALMA WAGELEY  |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>November 3, 1982           |   | 2b. HOUR<br>3:30 P M |  |
| 3. SEX<br>Female  |  | 4. RACE<br>White   |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>Feb. 24, 1906   |                      |  |
| 6. AGE (IN YEARS LAST BIRTHDAY)<br>76 YRS.  |  | IF UNDER 1 YEAR<br>MONTHS DAYS   |   | IF UNDER 24 HRS.<br>HOURS MIN.  |                      |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA  |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |                      |  |
| 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Allegany MD.  |  |  |   |   |                      |  |
| 10. CITY OR TOWN OF DEATH<br>Cumberland   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Memorial Hospital |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Housewife   |                      |  |
| 12b. KIND OF BUSINESS OR INDUSTRY<br>In Own Home  |  |  |   |   |                      |  |
| 13a. STATE<br>Maryland  |  | 13b. COUNTY<br>Allegany  |   | 13c. CITY OR TOWN<br>Cumberland   |                      |  |
| 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  | 13e. STREET ADDRESS<br>204 Oak Street  |   |   |                      |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>John Dreyer   |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Elizabeth Schade |   |                      |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>no  |  | 16b. SOCIAL SECURITY NO.<br>214-05-4123  |   | 17. INFORMANT<br>ADDRESS<br>Mrs. Rosemarie De Martino, Cumberland, Md.  |                      |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Chronic</u><br><u>4860</u> DUE TO, OR AS A CONSEQUENCE OF <u>Dissection - respiration</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. }<br>(b) <u>Failure</u><br>(c) <u>Failure</u> |  |  |   |   |                      |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a)  |  |  |   |   |                      |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |                      |  |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |  |  |   |   |                      |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |                      |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(1st HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |                      |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>11/3/82</u> to <u>11/3/82</u> , that (I) (we) last saw the deceased alive on <u>11/3/82</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.  |  |  |   |   |                      |  |
| 22b. SIGNATURE<br><u>Dr. Guy Fiscus</u>   |  | DEGREE<br>MD   |   | 22c. DATE SIGNED<br>11/5/82   |                      |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Dr. Guy Fiscus   |  | 22e. ADDRESS<br>Medical Building<br>Memorial Hospital, Cumberland, MD 21502  |   |   |                      |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial  |  | 23b. DATE<br>Nov. 6, 1982  |   | 23c. NAME OF CEMETERY OR CREMATORY<br>Greenmount Cemetery   |                      |  |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Cumberland, Allegany, Md.   |  | 24. FUNERAL DIRECTOR<br>NAME<br>James F. Scarpelli, Cumberland, Md.  |   |   |                      |  |
| 24b. DATE RECEIVED BY REGISTRAR<br>NOV 8 1982   |  | 24c. REGISTRAR'S SIGNATURE<br><u>John J. [Signature]</u>   |   |   |                      |  |

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MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

C3

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 10 days of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of this.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |                                     |  |   |  | REG. NO. 8 2 2 7 1 2 8  |  |  |  |          |
|---|-------------------------------------|--|---|--|---|--|--|--|----------|
| 1. FOR STATE REGISTRAR  |                                     |  |   |  | 7a. DATE OF DEATH MONTH DAY YEAR  |  |  |  | 7b. HOUR |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST<br>EDNA ELRICK WALTERS   |                                     |  |   |  | 11-9-82   |  |  |  | 605 AM   |
| 3. SEX<br>F   | 4. RACE<br>W                        | 5. DATE OF BIRTH MONTH DAY YEAR<br>12 9 1898   |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br>✓ 81 YRS.                                   |   | IF UNDER 1 YEAR MONTHS DAYS  |  | IF UNDER 24 HRS. HOURS MIN.                  |          |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>MD.  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Allegany MD.  |  |  |  |          |
| 10. CITY OR TOWN OF DEATH<br>Frostburg  |                                     | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>FROSTBURG VILLAGE NRSg. HOME |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Housewife                      |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Home  |  |          |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |                                     |  |   |  | 13a. STREET ADDRESS   |  |  |  |          |
| 13a. STATE<br>MD.   |                                     | 13b. COUNTY<br>Allegany  | 13c. CITY OR TOWN<br>Frostburg  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br>282 E. Main STREET.   |  |          |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>John E. ELRICK   |                                     |  |   |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>Isabel STURTZ                                     |  |  |  |          |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br>No   |                                     | 16b. SOCIAL SECURITY NO.<br>214-74-5927  |   | 17. INFORMANT ADDRESS<br>Marion Charles 1 Barnard Place, Fbg. MD               |   |  |  |  |          |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY<br>4140 IMMEDIATE CAUSE (a) Cardiac failure -<br>DUE TO, OR AS A CONSEQUENCE OF (b) Congestive heart failure<br>DUE TO, OR AS A CONSEQUENCE OF (c) AHD.  |                                     |  |   |  |   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |          |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I.<br>old age. Abscess 2 intra abd. malignancy. Joint Pathology   |                                     |  |   |  |   |  |  |  |          |
| 19a. DATE OF OPERATION  |                                     | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                       |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |          |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |                                     | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |   |  |  |  |          |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK  |                                     | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE                                 |   |  |  |  |          |
| 22a. I certify that (I) (this hospital) attended the deceased from 6/29, 1982, to 11/9, 1982, that (I) (we) lost<br>saw the deceased alive on 11-3, 1982, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did not) view the body after death. |                                     |  |   |  |   |  |  |  |          |
| 22b. SIGNATURE<br>S. Sandhir  |                                     |  |   | DEGREE<br>MD   |   | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED                             |          |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>S. Sandhir   |                                     |  |   | 22e. ADDRESS<br>48 Tarn Terrace Frostburg, MD                                  |   |  |  |  |          |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial   |                                     | 23b. DATE<br>11-11-1982  |   | 23c. NAME OF CEMETERY OR CREMATORY<br>Frostburg, Mem. Park                     |   | 23d. LOCATION CITY OR TOWN COUNTY STATE<br>Frostburg, Allegany, MD   |  |  |          |
| 24. FUNERAL DIRECTOR NAME<br>John J. Hafer, Jr  |                                     |  |   | ADDRESS<br>LaVale, Maryland  |   | 25a. DATE REC'D. BY REGISTRAR<br>NOV 15 1982   |  | 25b. REGISTRAR'S SIGNATURE<br>John J. Hafer  |          |

Home

Postoffice

Section Chief, Forward Place, Twp. 10

AS Twp. Forward Place, Twp. 10

AS Twp. Forward Place, Twp. 10

NOV 18 1932  
John J. Baker

LaVale, Maryland

John J. Baker, Jr.

11-13-32

11-13-32



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|--|----------------------------------|--|--|
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>              | 23b. DATE<br><b>Dec. 1, 1982</b> | 23c. NAME OF CEMETERY OR CREMATORY<br><b>SS. Peter &amp; Paul Cem.</b> | 23d. LOCATION<br>CITY OR TOWN<br><b>Cumberland, Allegany, Md.</b><br>COUNTY<br>STATE                     |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>James F. Scarpelli, Cumberland, Md.</b> |                                  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>DEC 7 1982</b><br>25b. REGISTRAR'S SIGNATURE<br><i>John J. Gault</i> |

**TO MEDICAL EXAMINER:** THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE WRITE THE REASON THEREFOR IN THE SPACE PROVIDED. IN THE EVENT OF A DELAY, THIS CERTIFICATE MUST BE FORWARDED TO THE MEDICAL EXAMINER WITHIN 72 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DHMH - 17  
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral home, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |   |  | 8 2 2 7 7 3 0   |  |  |  |
|--|--|---|--|---|--|--|--|
| 1. FOR STATE REGISTRAR   |  |   |  | REG. NO.  |  |  |  |
| 1. DECEASED NAME (TYPE OR PRINT)<br><b>Virgie MAE Willison</b>   |  |   |  | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>11/17/82</b>   |  | 2b. HOUR<br><b>4:15p</b> M   |  |
| 3. SEX<br><b>female</b>  |  | 4. RACE<br><b>white</b>   |  | 5. DATE OF BIRTH MONTH DAY YEAR<br><b>8/16 1905</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>77</b> YRS.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>West Virginia</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Allegany Co</b> MD.   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Frostburg</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Frostburg Community Hospital</b> |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Employee</b>  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Textile</b>  |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |  |   |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |  |  |
| 13a. STATE<br><b>Maryland</b>  |  | 13b. COUNTY<br><b>Allegany</b>  |  | 13c. CITY OR TOWN<br><b>Flintstone</b>  |  | 13e. STREET ADDRESS<br><b>Rt #2- Murley's Branch</b>   |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br><b>George Thomas DuVall</b>   |  |   |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><b>Sarah Mallory</b>  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>No</b>   |  |   |  | 16b. SOCIAL SECURITY NO.<br><b>217-10-5368</b>  |  | 17. INFORMANT ADDRESS<br><b>J ROBISON 48 Tarn Terrace, Frostburg Md</b>  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY:<br><b>2859</b> IMMEDIATE CAUSE (a) <b>RENAL FAILURE</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>CHRONIC RENAL DISEASE</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(c) <b>ANEMIA SECONDARY TO (b)</b> |  |   |  |   |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)<br><b>ACUTE PYELONEPHRITIS PARKINSON'S DISEASE</b>  |  |   |  |   |  |  |  |
| 19a. DATE OF OPERATION<br><b>NONE</b>  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>11/7</b> , 19 <b>82</b> , to <b>11/17</b> , 19 <b>82</b> , that (I) (we) lost saw the deceased alive on <b>19 82</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                    |  |   |  |   |  |  |  |
| 22b. SIGNATURE<br><b>S. Chang M.D.</b>   |  |   |  | DEGREE<br><b>M.D.</b>   |  | 22c. DATE SIGNED<br><b>11/18/82</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>SATURNINA T. CHANG, M.D.</b>   |  |   |  | 22e. ADDRESS<br><b>34 BROADWAY FROSTBURG, MD 21502</b>  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>   |  | 23b. DATE<br><b>Nov 20, 1982</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Hillcrest Burial Park Cumberland Allegany Maryland</b>   |  | 23d. LOCATION CITY OR TOWN COUNTY STATE  |  |
| 24. FUNERAL DIRECTOR<br><b>Sitcox-Funeral Home</b>   |  |   |  | 25a. DATE REC'D. BY REGISTRAR (BY REGISTRAR'S SIGNATURE)<br><b>NOV 22 1982</b>  |  | 25b. REGISTRAR'S SIGNATURE<br><b>John Smith</b>  |  |

BP

STATE OF ALABAMA  
DEPARTMENT OF SOCIAL SECURITY  
BIRMINGHAM, ALABAMA

|        |       |      |      |           |
|--------|-------|------|------|-----------|
| Female | White | 2/16 | 1905 | Albany Co |
| Female | White | 2/16 | 1905 | Albany Co |
| Female | White | 2/16 | 1905 | Albany Co |
| Female | White | 2/16 | 1905 | Albany Co |
| Female | White | 2/16 | 1905 | Albany Co |
| Female | White | 2/16 | 1905 | Albany Co |
| Female | White | 2/16 | 1905 | Albany Co |
| Female | White | 2/16 | 1905 | Albany Co |
| Female | White | 2/16 | 1905 | Albany Co |
| Female | White | 2/16 | 1905 | Albany Co |

21-10-5555 J ROBINSON 25 TOWN TOWNSHIP FROSTBURG MD

21-10-5555 J ROBINSON 25 TOWN TOWNSHIP FROSTBURG MD

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21-10-5555 J ROBINSON 25 TOWN TOWNSHIP FROSTBURG MD

21-10-5555 J ROBINSON 25 TOWN TOWNSHIP FROSTBURG MD

Nov 26, 1972  
Albany Co  
Frostburg, MD

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 2 7 7 3 1

1. FOR  
STATE  
REGISTRAR

REG. NO.

|   |  |   |   |  |  |
|---|--|---|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>CHESTER ALAN WILSON  |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>November 14, 1982  |  | 2b. HOUR<br>6:00 P.M.  |
| 3. SEX<br>Male  | 4. RACE<br>White   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>Feb. 21, 1908   |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br>74 YRS.   | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland   | 7b. CITIZEN OF WHAT COUNTRY?<br>USA  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Allegany MD.                                       |  |
| 10. CITY OR TOWN OF DEATH<br>Cumberland   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Memorial Hospital |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Mechanic                    | 12b. KIND OF BUSINESS OR INDUSTRY<br>Retired   |  |
| 13a. STATE<br>Maryland  | 13b. COUNTY<br>Allegany  | 13c. CITY OR TOWN<br>Cumberland   | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 13e. STREET ADDRESS<br>Rt. #3, Box 179, Bedford Rd.  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Henry Wilson  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Margaret Dawson  |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No  |  | 16b. SOCIAL SECURITY NO.<br>214-07-1060   |   | 17. INFORMANT ADDRESS<br>Roberta M. Wilson, Cumberland, Md.<br>21502                       |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Respiratory arrest</u><br>4360<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>aspiration pneumonia</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>CVA &amp; CAD</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |   |   |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: 10   |  |   |   |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)             |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>11/14</u> , 19 <u>82</u> , to <u>11/14</u> , 19 <u>82</u> , that (I) (we) lost<br>saw the deceased alive on <u>11/14</u> , 19 <u>82</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death.                               |  |   |   |  |  |
| 22b. SIGNATURE<br><u>T. Elder</u>   |  | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>        |   | 22c. DATE SIGNED<br>11/15/82   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Dr. T. Elder   |  | 22e. ADDRESS<br>Medical Building<br>Memorial Hospital, Cumberland, MD 21502   |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial  | 23b. DATE<br>Nov. 17, 82   | 23c. NAME OF CEMETERY OR CREMATORY<br>Hillcrest Burial Pk.  |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Cumberland, All. Maryland                    |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>William G. Kight, Cumberland, Md.   |  | ADDRESS   |   | 25a. DATE RECD. BY REG. OR PAR. 1311 REGISTRAR'S SIGNATURE<br>11/17/82 <u>John J. Lohr</u> |  |

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Please do not retain by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, please detach for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of same.

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 2 7 7 3 2

REG. NO.

|   |  |  |  |   |  |  |  |  |
|---|--|--|--|---|--|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>Lillie Yeider</b>   |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>11/5/82</b>                  |   | 2b. HOUR<br><b>11 a</b> M  |  |  |  |
| 3. SEX<br><b>female</b>   |  | 4. RACE<br><b>white</b>  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>3/ 14/ 91</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>91</b> YRS.                        |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Allegany County</b> MD.       |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Frostburg, MD.</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Frostburg Community Hospital</b> |  |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Homemaker</b> |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Own Home</b>   |  |
| 13a. STATE<br><b>Maryland</b>   |  |  | 13b. COUNTY<br><b>Allegany</b>   |   | 13c. CITY OR TOWN<br><b>Frostburg</b>  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                            |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Robert Walsh</b>   |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Amelia Whetzel</b> |   |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES <input type="checkbox"/> UNKNOWN <input checked="" type="checkbox"/> (IF YES, GIVE WAR OR DATES)<br><b>unknown</b>   |  |  | 16b. SOCIAL SECURITY NO.<br><b>216 46 4238</b>                         |   | 17. INFORMANT<br>ADDRESS<br><b>J Robison 48 Tarn Terrace, Frostburg, Md.</b>         |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardiac failure</b><br>5119<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>C.H.F. pneumonia</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>plumery, ASVD</b><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |  |  |   |  |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |  |  |   |  |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>Nov 1, 1982</b> to <b>Nov 9, 1982</b> that (I) (we) lost<br>saw the deceased alive on <b>Nov 5, 1982</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) (see) the body after death.   |  |  |  |   |  |  |  |  |
| 22b. SIGNATURE<br><b>Dr. S. Kim</b> M.D.<br>DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>  |  |  |  |   |  | 22c. DATE SIGNED   |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Dr. S. Kim</b>  |  |  |  |   |  | 22e. ADDRESS<br><b>Main St., Westernport, MD.</b>                        |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>   |  | 23b. DATE<br><b>Nov. 7, 1982</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Frostburg Mem. Park</b>  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Frostburg, Maryland</b> |  |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Durst Funeral Home Frostburg, Md.</b>  |  |  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>NOV 12 1982</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><b>J. C. Connelley</b>                     |  |  |

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|  |          |                              |      |        |       |     |         |
|--|----------|------------------------------|------|--------|-------|-----|---------|
| 11 a   | 11/25/02 | Yelder                       | Life | Female | White | USA | Unknown |
| 91   | 91       | 91                           | 91   | 91     | 91    | 91  | 91      |
| Allegany County                                      |          | X                            |      |        |       |     |         |
| Frostburg, MD  |          | Frostburg Community Hospital |      |        |       |     |         |
| 216 46 4238 J Robinson 48 Tarn Terrace Frostburg, MD |          |                              |      |        |       |     |         |

*Carbon failure  
CUT  
Planned. 12/20/02*



*Handwritten signature and date: 12/20/02*

Main St., Westminster, MD

Dr. S. Kim

Frostburg, MD

Durst Funeral Home

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with 15 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |   |  | 8 2 2 7 7 3 3<br>REG. NO.  |  |   |  |
|--|--|---|--|--|--|---|--|
| 1. FOR STATE REGISTRAR   |  |   |  |  |  |   |  |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST<br>HELEN RUBY ZIMMERMAN   |  |   |  | 2a. DATE OF DEATH MONTH DAY YEAR<br>NOVEMBER 28, 1982  |  | 2b. HOUR<br>11:15 PM  |  |
| 3. SEX<br>Female   |  | 4. RACE<br>White  |  | 5. DATE OF BIRTH MONTH DAY YEAR<br>Aug. 25, 1910   |  | 6. AGE (IN YEARS LAST BIRTHDAY) MONTHS DAYS<br>72 YRS.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>West Virginia   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>ALLEGANY COUNTY, MD.  |  |
| 10. CITY OR TOWN OF DEATH<br>Cumberland  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>SACRED HEART HOSPITAL |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Housekeeper   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>In Own Home  |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE COUNTY<br>W. Va. Mineral Ridgeley   |  |   |  | 13b. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  | 13c. STREET ADDRESS<br>2 John Street  |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>Samuel F. Zimmerman   |  |   |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>Maggie Steckman  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br>no  |  | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)<br>235-32-7166   |  | 17. INFORMANT ADDRESS<br>Mrs. Elma Wolfe, Ridgeley, W. Va. Sister  |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), or (c).)<br>PART I. DEATH WAS CAUSED BY:<br>1539 IMMEDIATE CAUSE (a) Pulmonary embolism<br>DUE TO OR AS A CONSEQUENCE OF (b) Old Carcinoma, metastatic<br>DUE TO OR AS A CONSEQUENCE OF (c) Cholelithiasis<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. |  |   |  |  |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)   |  |   |  |  |  |   |  |
| 19a. DATE OF OPERATION<br>11/26/82   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br>Cholelithiasis - cholecystectomy  |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)  |  |   |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |  |   |  |
| 22a. I certify that (he/she) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) sign the death certificate.  |  |   |  |  |  |   |  |
| 22b. SIGNATURE<br>A. B. Flores   |  |   |  | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>     |  | 22c. DATE SIGNED  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>AUBERTO FLORES, M.D.  |  |   |  | 22e. ADDRESS<br>924 SETON DR., CUMBERLAND, MD 21502  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial  |  | 23b. DATE<br>12-2-1982  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Sunset Memorial Park   |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br>Cumberland Allegany Md.  |  |
| 24. FUNERAL DIRECTOR NAME<br>SCARPELLI FUNERAL HOME  |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br>DEC 7 1982  |  | 25b. REGISTRAR'S SIGNATURE<br>John J. [Signature]   |  |
| 25c. ADDRESS<br>108 VIRGINIA AVE. CUMBERLAND, MD 21502   |  |   |  |  |  |   |  |

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